DEPARTMENT OF INSPECTIONS AND APPEALS ok

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0415	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE PLACE - CONNECTIONS	2115 1ST AVENUE SE 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 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: 2 Number of tenants with cognitive impairment: 14 Total census: 16 The following regulatory insufficiencies were cited during the investigation of Complaint #108624-C and the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	A 000	See Attached POC 7/28/23	
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. This pertained to 1 of 3 current tenants reviewed (Tenant #3) and 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 4/17/23 of Tenant #3's file revealed a Program document indicated on 1/20/23 Tenant #3 and Tenant #4 were seated together at the the table for a meal. Tenant #4 raised his voiced and staff observed Tenant #3 standing over Tenant #4 and was trying to put his	A 150		

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		

napkin in Tenant #4's mouth. Tenant #3 was mad and picked up his napkin and threw it at Tenant #4. On 1/23/23 it was noted staff was educated to keep Tenant #3 and Tenant #4 at different tables for meals.

Continued record review of Tenant #3's file revealed an incident report was not completed related to the incident between Tenant #3 and Tenant #4 on 1/20/23. An incident report was not completed per policy and procedure.

2. Record reivew on 4/17/23 of Tenant C1's file revealed a nurse's notes dated 8/25/22 indicated the Assisted Living Director of Nursing (DON) was called to Tenant C1's apartment to assess her left shoulder/chest area. Tenant C1 had a large purple bruise and she had complaints of pain when she moved it. Tenant C1's family was contacted and wanted to her be seen by her primary care provider (PCP) at the Program on 8/26/22. The PCP office was contacted and wanted her sent out to the emergency department (ED) for x-rays. Tenant C1 was sent out by ambulance.

Continued record review revealed a nurse' note from the attached long term care center dated 8/29/22 indicated Tenant C1 was admitted to intermediate level of care from the hospital due to a fractured left clavicle.

Further record review of Tenant C1's file revealed an incident report was not completed related to Tenant C1 injury of unknown origin noted on 8/25/22. An incident report was not completed per policy and procedure.

3. When interviewed on 4/13/23 at 1:14 p.m. Staff A said Tenant C1 had moved to the attached

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A 150	Continued From page 2	A 150		

care center. When she was at the Program staff found her on the bed and she had a bruise. It was assumed she fell and got herself up. The Assisted Living DON said it was necessary to take her to the ED. Staff A accompanied her to the hospital as she did not have any family that could accompany her. Staff A kept in contact with the Assisted Living DON and Tenant C1's family while at the hospital with Tenant C1. She kept in communication with them via telephone calls or if a text, would not use Tenant C1's name. Staff A said staff could not post anything (tenant information) on social media, including medical information or name. She also said pictures could not be taken on a cell phone. Staff A denied posting anything on social media with tenant information and was not aware of any staff that had done so.

When interviewed on 4/18/23 at 12:33 p.m. Staff G said one staff post an image of her next to a hospital bed but you could not see the person's face and or anything identifying. Staff G said Staff A posted it on her personal snap chat. Staff G thought it was about a family member of Staff A and sent her a snap inquiring about it. Staff A said she was in the hospital with Tenant C1 and she had broken her shoulder. She was not sure who all received it.

When observed on 4/17/23 an image was provided that showed a conversation between two staff in dialogue boxes dated 8/26/22. The dialogue boxes between the two staff, included a first name that was also Tenant C1's first name and that the person (Tenant C1) was in the ED. There was not a picture provided with dialogue boxes.

Staff did not follow the Program's social media

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A 150	Continued From page 3 and confidentiality and privacy policies and procedures related to Tenant C1. 4. Record review revealed the Program's social media and confidentiality and privacy policies and procedures indicated the principles and guidelines in the Program's policy applied to staffs' social media content. Staff members were responsible for what information was posted. Staff would not disclose trade secrets, confidential or private information. That included patient confidential and private information. Continued record review revealed the Program's Accident and Emergency Response policy and procedure indicated all accidents or unusual occurrences that affect tenants would be incidents. An incident report would be available for staff to complete and needed to be completed in detail. 5. When interviewed on 4/17/23 at 1:14 p.m. and 5/3/23 at 11:42 a.m. the Assisted Living Administrator confirmed there were no incident reports completed related to the incident between Tenant #3 and Tenant #4 or with Tenant C1's incident. She said staff should not be posting anything about tenants on their personal social media and she was not aware of any staff that had shared private tenant information on social media. She said staff had a group message application for work purposes.	A 150		
A 106	231C.5 1 Occupancy Agreement 231C.5 Written occupancy agreement required. 1. An assisted living program shall not operate in this state unless a written occupancy agreement,	A 106		

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A 106	Continued From page 4	A 106		

as prescribed in subsection 2, is executed between the assisted living program and each tenant or the tenant's legal representative, prior to the tenant's occupancy, and unless the assisted living program operates in accordance with the terms of the occupancy agreement. The assisted living program shall deliver to the tenant or the tenant's legal representative a complete copy of the occupancy agreement and all supporting documents and attachments and shall deliver, at least thirty days prior to any changes, a written copy of changes to the occupancy agreement if any changes to the copy originally delivered are subsequently made.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the Program failed to obtain signed occupancy agreements prior to tenants taking occupancy. This pertained to 2 of 3 current tenants reviewed (Tenant #1 and Tenant #3). Findings follow:

1. Record review on 4/17/23 of Tenant #1's file revealed Tenant #1 was admitted on 12/16/21. A Clinical Note Entry dated 12/16/21 indicated Tenant #1 was admitted "today" (12/16/21) from skilled care. The Tenant Assisted Living Memory Care Agreement was signed on 12/31/21, by Tenant #1's legal representative and a Program representative. Tenant #1 was admitted prior to the signing of the occupancy agreement.

2. Record review on 4/17/23 of Tenant #3's file revealed Tenant #3 was admitted on 5/31/22. A Clinical Note Entry dated 5/31/22 indicated Tenant #3 moved from assisted living to assisted living memory care. The Tenant Assisted Living Memory Care Agreement was signed on 6/9/22 by Tenant #3's legal representative and a

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A 106	Continued From page 5 Program representative. Tenant #3 was admitted prior to the signing of the occupancy agreement. 3. When interviewed on 5/3/23 at 11:42 a.m. the Assisted Living Administrator confirmed the occupancy agreements available were provided for the tenants listed above.	A 106		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 3 of 3 current tenants reviewed (Tenants #1, #2 and #3) and 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 4/17/23 of Tenant #1's file revealed daily report sheets indicated the following: -On 1/7/23 on second shift it was noted staff provided several reminders to stay out of other tenants' apartments -On 1/10/23 on first shift it was noted Tenant #1	A 290		

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A 290	Continued From page 6 chased staff out of his apartment -On 1/10/23 on second shift it was noted Tenant #1 wandered a lot -On 1/13/23 on second shift it was noted Tenant #1 walked the hallways and he shoved staff when they attempted to redirect him from going into other tenants' apartments -An undated daily report sheet (from April 2023) on third shift noted Tenant #1 was out and was exit seeking and then went back to sleep Continued record review of Tenant #1's file revealed documented entries in nurse's notes were completed included for falls, follow up to the falls and new orders. Nurse's notes were not documented related to Tenant #1 wandering, behavior towards staff and exit seeking. 2. Record review on 4/17/23 of Tenant #2's file revealed daily report sheets indicated the following: -On 4/3/23 on first shift it was noted Tenant #2 was wandering -On 4/5/23 on third shift it was noted Tenant #2 refused toileting three times -On 4/6/23 on first shift it was noted Tenant #2 was wandering -On 4/7/23 on first shift it was noted Tenant #2 was wandering -On 4/7/23 on second shift it was noted Tenant #2 refused all cares	A 290		

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A 290	Continued From page 7	A 290		

-On 4/14/23 on third shift it was noted Tenant #2 was wandering

-On 4/15/23 on first shift it was noted Tenant #2 refused her shower

-On 4/16/23 on first shift it was noted Tenant #2 refused to have her clothes changed

-On 4/16/23 on second shift it was noted Tenant #2 attempted to hit staff and she had received several prompts to leave another tenants' apartment

Continued record review of Tenant #2's file revealed there were two entries in nurse's notes for Tenant #2 in the past three months, one entry dated 2/28/23 for a fall and one entry dated 3/3/23 regarding a fax received related to the fall.

3. Record review on 4/17/23 of Tenant #3's file revealed a Program document indicated on 1/20/23 Tenant #3 and Tenant #4 were seated together at the the table for a meal. Tenant #4 raised his voiced and staff observed Tenant #3 standing over Tenant #4 and was trying to put his napkin in Tenant #4's mouth. Tenant #3 was mad and picked up his napkin and threw it at Tenant #4. On 1/23/23 it was noted staff was educated to keep Tenant #3 and Tenant #4 at different tables for meals.

Continued record review of Tenant #3's file revealed a nurse's note was not completed related to the incident on 1/20/23.

4. Record review on 4/17/23 of Tenant C1's file revealed Tenant C1 was discharged on 12/1/22. An entry in nurse's notes was not documented related to her discharge from the Program.

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A 290	Continued From page 8 5. When interviewed on 5/3/23 at 11:42 a.m. the Assisted Living Administrator confirmed all nurse's notes were provided for the tenants listed above.	A 290		
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 develop service plans that reflected the service needs of the tenants. This pertained to 3 of 3 current tenants reviewed (Tenants #1, #2 and #3) and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow: 1. Record review on 4/17/23 of Tenant #1's file revealed daily report sheets indicated the following: -On 1/7/23 on second shift it was noted staff provided several reminders to stay out of other tenants' apartments -On 1/10/23 on first shift it was noted Tenant #1 chased staff out of his apartment	A 350		

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A 350	Continued From page 9	A 350		

-On 1/10/23 on second shift it was noted Tenant #1 wandered a lot

-On 1/13/23 on second shift it was noted Tenant #1 walked the hallways and he shoved staff when they attempted to redirect him from going into other tenants' apartments

-An undated daily report sheet (from April 2023) on third shift noted Tenant #1 was out and was exit seeking and then went back to sleep

When interviewed on 4/13/23 at 1:14 p.m. Staff A said Tenant #1 had behavior that needed redirection, it more towards staff and had improved since his medications were adjusted. She said he tried all of the doors and went to next door and he was very adamant about it. She said it occurred approximately three times per day.

When interviewed on 4/13/23 Staff F said Tenant #1 had exit seeking behavior and the frequency was every other day. He moved around furniture, grabbed a walker, went into other tenants' apartments, was exit seeking and tried to open the doors.

Continued record review revealed a Physician's Order Sheet reflected orders including:

-quetiapine 50 milligram (mg), take one tablet, twice daily, ordered on 1/16/23

-quetiapine 25 mg/0.2 milliters (ml), pen cream, apply 4 ml (50 mg), topically every six hours as needed, ordered on 1/13/23.

Further record review revealed nurse's notes indicated Tenant #1 had falls on 12/25/22, 12/29/22, 1/18/23, 1/25/23, 1/31/23, 2/3/23,

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A 350	Continued From page 10 2/8/23, 3/4/23, 3/10/23, 3/26/23, 3/30/23 and 4/3/23. Continued record review of Tenant #1's service plan signed 12/22/22 reflected Tenant #1 at times focused on leaving the unit and tried to open locked doors. Tenant #1 wandered into other tenants' apartments and staff were to redirect him. The service plan reflected the wandering behavior and to redirect him; however, did not reflect interventions or redirection for the behavior. The service plan also did not reflect the as needed topical quetiapine cream and Tenant #1's history of behavior toward staff. The service plan also reflected Tenant #1 had falls; however, did not provide any interventions related to his falls. 2. Record review on 4/17/23 of Tenant #2's file revealed daily report sheets indicated the following: -On 4/3/23 on first shift it was noted Tenant #2 was wandering -On 4/5/23 on third shift it was noted Tenant #2 refused toileting three times -On 4/6/23 on first shift it was noted Tenant #2 was wandering -On 4/7/23 on first shift it was noted Tenant #2 was wandering -On 4/7/23 on second shift it was noted Tenant #2 refused all cares -On 4/14/23 on third shift it was noted Tenant #2 was wandering	A 350		

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A 350	Continued From page 11 -On 4/15/23 on first shift it was noted Tenant #2 refused her shower -On 4/16/23 on first shift it was noted Tenant #2 refused to have her clothes changed -On 4/16/23 on second shift it was noted Tenant #2 attempted to hit staff and she had received several prompts to leave another tenants' apartment When interviewed on 4/13/23 at 1:14 p.m. Staff A said Tenant #2 did refuse cares but it did not happen every time. She said Tenant #2 was combative at times with staff related to cares. Staff did not have any injuries but she did swing at staff if staff continued cares. Record review of the ALP Monitoring Entrance Form indicated Tenant #2 was identified as a tenant that wandered and a tenant that consistently refused cares and services. Continued record review revealed Tenant #2's service plan signed 2/10/23 indicated the service plan did not reflect Tenant #2's refusals of cares at times, wandering, and combative behavior at times with cares. 3. Record review on 4/17/23 of Tenant #3's file an incident report dated 12/16/22 reflected staff heard yelling and responded to Tenant #4's apartment. Tenant #4 was laying the couch and Tenant #3 grabbed his arms above him. Staff took Tenant #3 out of the apartment and Tenant #3 showed staff a skin tear on his arm. Tenant #4 said Tenant #3 came into his apartment and offered him cookies, which he declined. Tenant #3 became upset, put his hands on him, Tenant #4 punched him in the face and Tenant #3	A 350		

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A 350	Continued From page 12 grabbed him. Continued record review of a Program document indicated on 1/20/23 Tenant #3 and Tenant #4 were seated together at the the table for a meal. Tenant #4 raised his voiced and staff observed Tenant #3 standing over Tenant #4 and was trying to put his napkin in Tenant #4's mouth. Tenant #3 was mad and picked up his napkin and threw it at Tenant #4. On 1/23/23 it was noted staff was educated to keep Tenant #3 and Tenant #4 at different tables for meals. Further record review revealed nurse's notes dated 1/20/23 indicated all scheduled oral medications except two medications were discontinued. As needed medications remained. Continued record review revealed Tenant #3's service plan signed on 1/9/23 reflected Tenant #3 refused medications and there was a discussion about possibly discontinuing medications. The service plan did not reflect most scheduled oral medications were discontinued and it also did not Tenant #3's behavior towards/with another tenant (Tenant #4). 4. Record review on 4/17/23 of Tenant C2's file revealed an After Visit Summary dated 12/12/22 indicated Tenant C2 was seen in the emergency department including for a fall and scalp laceration. The orders indicated to have the staples removed in 5 to 7 days, to keep the wound clean and dry and to apply antibiotic ointment to the wound twice daily. Continued record review revealed the service plans signed on 12/5/22 and 12/14/22 did not reflect Tenant C2's fall with head injury, the staples, treatment or staples removal.	A 350		

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A 350	Continued From page 13 5. When interviewed on 5/3/23 at 11:42 a.m. the Assisted Living Administrator confirmed the most recent service plans for the tenants listed above was provided.	A 350		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received eight hours of dementia specific training within 30 days of employment. This pertained to 2 of 4 staff reviewed hired in 2022 (Staff B and Staff C). Findings follow: 1. Record review on 4/13/23 of Staff B's training documents revealed Staff B was hired on 12/14/22. Training documents revealed Staff B did not have eight hours of dementia specific training completed within 30 days of employment. 2. Record review on 4/13/23 of Staff C's training documents revealed Staff C was hired on 10/24/22. Training documents revealed Staff C did not have eight hours of dementia specific training completed within 30 days of employment. 3. When interviewed on 5/3/23 at 11:42 a.m. the	A 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0415	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE PLACE - CONNECTIONS	2115 1ST AVENUE SE 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 545	Continued From page 14 Assisted Living Administrator confirmed all dementia education for the staff listed above was provided.	A 545		
A 556	481-69.30(3)b Dementia-Specific Education for Personnel 69.30(3) Dementia-specific continuing education b. Direct-contact personnel employed by or contracting with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received eight hours of dementia specific education annually. This pertained to 1 of 1 staff reviewed due for annual dementia specific training (Staff A). Findings follow: 1. Record reivew on 4/13/23 of Staff A's training documents revealed Staff A was hired on 10/4/21. Staff A had eight hours of dementia specific education completed within 30 days of employment. Staff A had completed dementia education in 2022 and 2023; however, eight hours of dementia specific education was not completed annually. 2. When interviewed on 5/3/23 at 11:42 a.m. the Assisted Living Administrator revealed the monthly training had been removed from the	A 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0415	A. BUILDING: _____ B. WING _____	C 05/03/2023

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(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 556	Continued From page 15 training schedule (inadvertently) and it had not been assigned. She confirmed all dementia training was provided for the staff listed above.	A 556		
A 565	481-69.30(5) Dementia Specific Education for Personnel 69.30(5) Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, Web-based training, and case studies of tenants in the program This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide hands-on dementia specific training for staff. This pertained to 3 of 3 staff that had eight hours of dementia specific training completed within 30 days of employment (Staff A, D and E). Findings follow: 1. Record review on 4/13/23 of Staff A's training documents revealed Staff A was hired 10/4/21. Staff A had eight hours of dementia specific training completed within 30 days of employment; however, the training provided was a web based-training and lacked any documented hands-on dementia specific training. 2. Record review on 4/13/23 of Staff D's training document revealed Staff D was hired on 9/11/22. Staff D had eight hours of dementia specific training completed within 30 days of employment; however, the training provided was a web based-training and lacked any documented hands-on dementia specific training. 3. Record review on 4/13/23 of Staff E's training	A 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0415	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE PLACE - CONNECTIONS	2115 1ST AVENUE SE 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 565	Continued From page 16 documents revealed Staff E was hired on 1/28/22 and (had an ALP start date of 1/8/23). Staff E had eight hours of dementia specific training completed prior to her ALP start date; however, the training provided was a web based-training and lacked any hands-on dementia specific training. 4. When interviewed on 5/3/23 at 11:42 a.m. the Assisted Living Administrator said staff worked on the floor for three shift and had in person training; however, it was not formally documented. She confirmed all dementia training was provided for the staff listed above.	A 565		

Cottage Grove Place Connections Recertification

Plan of Correction from 04/12/2023 to 05/03/2023.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or State Law.

A 150 481-67.2(3) Program Policies and Procedures

Assisted Living Administrator and Assisted Living DON educated staff on 5/8/2023 at staff meeting on when staff should be completing incident reports. We also re-educated them on where to find the report sheets in the office area. AL DON will continue to monitor monthly to make sure incident reports are being completed when necessary. AL Administrator and DON went through resident files on 5/14/2023 to make sure no incident reports are missing.

A106 231C.5 1 Occupancy Agreement

The Assistant Living Administrator was provided education by the Executive Director on 06/13/23 regarding occupancy agreements must be signed prior to the tenant taking occupancy. Executive Director or designee will monitor quarterly for compliance.

A 290 481-69.25 (1) Tenant Documents

The Assisted Living DON will review all tenant records in the Connections program for proper documentation in the nurse's notes by 7/28/2023. The Assisted Living Administrator will monitor monthly for compliance.

Tenant #1 was discharged to a higher level of care on 05/5/2023.

Tenant #2 Tenants' nurse's notes will reflect exception documentation when appropriate.

Tenant #C1 was discharged to a higher level of care on 12/1/2022

A350 481-69.26(1) Service Plans

The Assisted Living Administrator educated the Assisted Living DON when to update service plans. AL DON and administrator audited all service plans in the Connections program for accuracy and to determine they properly reflect residents service needs on

7/28/2023. Service plans will be designed to meet the specific service needs of the individual tenant. Service plans will subsequently be updated and at least annually and whenever changes are needed.

Tenant #1 was discharged to a higher level of care on 5/5/2023.

Tenant #2 had service plan adjusted on 7/28/2023 identifying her regular tendency to wander, refusal of daily cares on occasion and occasional combativeness.

Tenant #3 was discharged to a higher level of care on 5/22/2023.

Tenant C2 was discharged from the program on 12/19/2022.

A 545 481-69.30 (1) Dementia Specific Education for Personnel

AL Administrator educated human resources department on 5/3/2023 regarding the requirement of 8 hours of dementia specific training annually. Like staff were audited by AL administrator for compliance on 05/04/2023.

A556 481-69.30 (3) Dementia Specific Education for Personnel

AL Administrator educated human resources department on 5/3/2023, that new staff is required to have 8 hours of dementia specific education within 30 days from start date. Like staff were audited by AL administrator for compliance on 05/04/2023.

A565 481-69.30 (5) Dementia Specific Education for Personnel

AL Administrator educated Director of Nursing that all new employees need 8 hours of hands-on floor training. AL administrator will monitor regularly. Like staff were audited by AL administrator for compliance on 05/04/2023.