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 |
|---|---|---|---|
| | 16427_hfd | A. BUILDING: _____ B. WING _____ | C 09/15/2021 |

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| COUNTRYHOUSE RESIDENCES | 5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411 |

| (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 |
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| A 000 | Initial Comments<br><br>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.<br><br>Number of tenants without cognitive disorder: 1<br>Number of tenants with cognitive disorder: 25<br><br>TOTAL Census of Assisted Living Program for People with Dementia: 26<br><br>An onsite infection control survey was completed and no regulatory insufficiencies were identified. The investigation of Complaint #99207-C was completed and the following regulatory insufficiencies were identified: | A 000 | POC attached 10/28/21 | |
| A 325 | 481-67.9(1) Staffing<br><br>67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review the Program failed to provide adequate supervision to tenants on the outside patio. This pertained to 2 of 2 tenants reviewed that fell outside in the courtyard (Tenants #2 and #3). This potentially affected all tenants (census of 26). Findings follow:<br><br>1. Record review revealed an incident report indicated on 8-16-21 at 8:10 p.m. Tenant #2 was found outside on the concrete patio. Tenant #2 was seated in his wheelchair with other tenants after the evening meal. Staff went out to the patio | A 325 | | |

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and observed Tenant #2 on the ground and there was blood on the ground from his head. Tenant #2 was able to talk and held staff's hand. Staff called 911 and Tenant #2 was taken to a hospital. The nurse on call was also notified. Staff stayed with Tenant #2 until emergency services arrived and gave the paperwork to them. The incident report indicated there were no witnesses and Tenant #2 sustained an laceration to the back of his head.

Observation on 8-25-21 of the video from 8-16-21 with Tenant #2 indicated the following:

-At 6:35 p.m. Staff B brought Tenant #2 outside to the patio in his wheelchair.

-At 7:04 p.m. Staff C was observed outside.

-At 7:06 p.m. Staff A was observed outside and Staff C was in the doorway.

-At 7:15 p.m. Tenant #2 stood up from his wheelchair and took a couple of steps and fell back towards a pillar and laid on his left side. There were no staff present during the time of the fall from what was observed on the video.

-At 7:26 p.m. Staff A responded and left.

-At 7:27 p.m. Staff A and Staff B both responded.

-At 7:39 p.m. paramedics arrived.

During the timeframe noted above there were other tenants observed outside on the patio, including five other tenants identified by the Director.

Continued record review of Tenant #2's file

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revealed a diagnosis of dementia with behavioral disturbance. Tenant #2 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline and he received hospice services. The most current service plan (not signed or dated) indicated Tenant #2 used a wheeled walker for an assistive device. Staff was to provide verbal prompting and encouragement as needed. Tenant #2 might require prompting on how to safely "navigate" throughout the building. Tenant #2 might be at risk for falls, he required occasional assistance of one person and staff to help stand up and was otherwise independent. Tenant #2 had routine safety hourly safety checks at night. The service plan reflected Tenant #2 would not be left unattended in his apartment during wake hours and the bedroom door was locked during wake hours. When Tenant #2 was napping or sleeping at night a motion senor was used. Staff would monitor the environment for safety when ambulating and transferring. Staff charted every two hours that the protocol was being upheld.

Further record review revealed incident reports indicated Tenant #2 had falls on 5-30-21, 6-10-21, 6-12-21 and 7-21-21. On 7-21-21 Tenant #2 was found on the floor of the theatre room next to his wheelchair, laying on his left side. Tenant #2's family member was with him, left for a brief time and returned to find him on the ground. Tenant #2 had a small laceration above the left eye and it was determined sutures would be needed. Tenant #2 was transported to a hospital for evaluation.

Continued record review revealed Observation (nurse's notes) for Tenant #2 dated 8-17-21 indicated the Wellness Director was notified last night that Tenant #2 had fallen while outside on

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the patio. It was not witnessed and Tenant #2 was found by a staff member. Tenant #2's head was bleeding, emergency services were called and he was taken to the hospital. Tenant #2's family was notified and met Tenant #2 at the emergency room. Tenant #2 returned to the Program and had six sutures to the back of his head. Tenant #2 had been seated on the patio with his walker nearby. It appeared he got up, attempted to ambulate and lost his balance.

Further record review revealed a change in condition assessment/nurse review, dated 10-21-20, reflected Tenant #2 was independent with ambulation and transfers but "often has an unsteady gait, which requires close supervision from staff."

Continued record review revealed a Long Term Care Facility Acute Visit document (encounter date 7-27-21) completed by the primary care provider (PCP) indicated Tenant #2 was seen for an acute visit, after being evaluated in the ER on 7-21-21 for a fall and facial laceration. For recurrent falls the "Assessment & Plan" indicated to use a wheelchair for mobility as Tenant #2 was "no longer able to safely ambulate." Tenant #2 had a history of falls with bilateral hip fractures.

A Video Incident Documentation document signed and dated by the Director on 8-25-21 reflected the following timeline from video at that time of the incident on 8-16-21 with Tenant #2:

-At 7:15 p.m. Tenant #2 fell walking to a chair on the patio.

-At 7:27 p.m. staff responded.

-At 7:39 p.m. paramedics arrived.

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When interviewed on 8-24-21 at 4:35 p.m. Staff A said it was about 7:00 p.m. to 7:30 p.m. and she was passing medications. She let a visitor out of the building and saw Tenant #2 on the ground. There was blood on the concrete and he was laying on his side. He was bleeding from the back of the head. Tenant #2 had been seated in his wheelchair. She called other staff (Staff B and Staff C) for help. She said Tenant #2 was outside approximately 25 minutes and she did not know when he was last seen prior to finding him on the ground. She was passing medications and the other two staff were assisting with cares and showers. The Wellness Director was notified. The ambulance and fire department arrived. There were other tenants outside with Tenant #2; however, she was not was not able to recall how many tenants were on the patio. The door to the patio was open at that time. Tenants sat outside in the courtyard (weather permitting) without staff and staff checked on them. There were no timeframe required for the checks.

When interviewed on 8-25-21 at 9:17 a.m. Staff B said she worked second shift and after supper she took Tenant #2 outside to sit at 6:30 p.m. and then she went to give a shower. Tenant #2 was in his wheelchair and the wheelchair brakes were locked. Staff A was passing medications, Staff B was giving a shower and Staff C was in checking in on them and taking people to the bathroom. When Staff C checked on him he was sitting in his wheelchair. Staff B did not know when Tenant #2 was last checked on (prior to his fall) as she was giving a tenant a shower. Staff A called and needed help. Tenant #2 was laying on his left side and his wheelchair was a little ways from

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him. Tenant #2 had a cut on his head, a towel was placed under his head and he was not moved. Staff called 911 and the Wellness Director was notified. Tenant #2 was taken to the hospital. She said there were eight tenants outside on the patio at that time and it was nice weather. Staff needed to be outside with the tenants or staff was to check on them. Staff C was back and forth checking on them.

When interviewed on 8-30-21 at 11:09 a.m. Staff C said she was working second shift and worked with Staff A and Staff B. After the evening meal staff took Tenant #2 and another tenant (also in a wheelchair) outside. Staff A was passing medications, Staff B was giving a shower and Staff C was taking tenants to the bathroom. Tenant #2 was taken outside to the patio between approximately 6:30 p.m. to 7:00 p.m. and was in his wheelchair. Tenant #2 was brought outside by either Staff A or Staff B. There was no staff sitting outside with the tenants and the door was open. Staff C was assisting with toileting other tenants and would come back and check on the tenants outside. Staff C said she checked on the tenants three to four times and they were doing okay and were sitting there. She had finished toileting another tenant and came out and saw Staff A and Staff B with Tenant #2 and they had called 911. When Staff C arrived Tenant #2 was laying on his side, a towel was placed under his head and he was responsive. Staff C said she had last checked on Tenant #2 approximately 10 minutes prior.

When interviewed on 8-25-21 the Wellness Director said the courtyard doors were locked unless opened by staff. The door could be left open and it was treated like the interior, as the courtyard was gated and secured. That occurred

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often, weather permitting. She said it was like other areas of the building, tenants could be unattended and the checks would vary depending on safety checks and toileting checks.
She received a telephone call from staff that Tenant #2 had fallen on the patio. Staff had called 911 and then called her. It appeared Tenant #2 was bleeding from the head and staff held pressure with a towel. She notified Tenant #2's family. Tenant #2 went to the hospital and returned the same day with sutures to back of his head. Tenant #2 had been sitting outside on the patio and appeared he tried to get up. There were no staff outside at the time and there other tenants outside. Staff A found him and then went to get help. Tenant #2 was sitting outside 20 to 30 minutes and she could not say if there was a visual check completed for Tenant #2. She said he was probably laying 10 to 15 minutes before staff found him. He had been sitting in the wheelchair and the wheelchair locks and foot pedals were on.
She completed an employee coaching form with Staff B as she used her personal cellular phone to call 911 and not the landline and where to find the exact address of the Program. She said it was approximately 30 minutes from when Tenant #2 fell until paramedics arrived.

When interviewed on 8-25-21 at 12:48 p.m. the Director said the tenants enjoyed being in the courtyard and it was healthy for them. When tenants were outside the door was propped open and staff was to keep an eye on the tenants as they would if they were sitting in the common area. Checks were completely similarly, when a tenant was inside or outside. The door to the courtyard had a battery back up, which was a secondary measure. It was turned off and on when the patio door was opened and closed. No

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other doors to the courtyard were left open and the gates to the courtyard were secured.
She was notified at 6:50 a.m. on 8-17-21 by the Wellness Director that Tenant #2 had fallen and went to the hospital. Tenant #2 got back at 11:30 p.m. on 8-16-21 and had received sutures. She was informed that Staff B used her personal cellular phone to call 911 and the Program's cordless phone should have been used. The Wellness Director said the paramedics were making a formal complaint that whoever called could not tell them the address.
Staff were not expected to sit outside but staff had eyes on them. There wasn't a policy that indicated a maximum time between checks unless the indicated checks were listed on the service plan and they were checked periodically with no specific timeframe for checks while outside.

When interviewed on 9-15-21 at 3:44 p.m. the Wellness Director confirmed when Tenant #2 fell there were no staff outside in the courtyard and staff responded in less than 15 minutes.

2. Record review of an incident report dated 8-17-21 at 1:00 p.m. revealed Tenant #3 was found on the ground outside on the patio. Tenant #3 was able to get up and denied pain. Tenant #3 said he tripped and fell on the ground. There were no injuries. The report indicated there were no witnesses.

Continued record review of Tenant #3's file revealed diagnoses included: Alzheimer's dementia without behavioral disturbance and Parkinson's disease. Tenant #3 was staged at a five on the GDS, which indicated moderate cognitive decline. The service plan (not dated or

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signed) indicated Tenant #3 might be at risk for falls, staff was to monitor for transfer and safety techniques and provided cueing as needed. A gait belt was to be used all times when staff assisted Tenant #3 with ambulation and transfers. Staff was to cue and provide verbal prompting as needed and hands-on assistance when needed for transfers. Tenant #3 received two hour safety checks at night and had a motion sensor in his apartment that was activated from 8:00 p.m. to 7:00 a.m. to ensure he was assisted when the motion senor went off.

When interviewed on 8-24-21 at 3:10 p.m. Staff D reported regarding Tenant #3's fall outside in the courtyard, that another tenant came and told staff Tenant #3 had fallen. Tenant #3 said he fell when he turned to sit down. Tenant #3 did not sustain any injuries. There were three other tenants outside on the patio when Tenant #3 fell. She estimated Tenant #3 could not have been outside more than five minutes. If it was nice outside, the patio was open and tenants would come and go. It was secured outside. She said checked on them when walking by and 90% of the time staff were outside with tenants.

A Video Incident Documentation document signed and dated by the Director on 8-25-21 reflected the following timeline from video at that time of the incident on 8-17-21 with Tenant #3:

-Tenant #3 ambulated with a walker out to the patio. He attempted to sit down without a chair behind him and fell at 12:45 p.m. Staff responded at 12:47 p.m.

Record review of the staffing policy (no procedure was provided) indicated the Program would

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| A 325 | Continued From page 9<br>provide a sufficient number of staff, with required training to meet tenants' needs including for supervision.<br><br>In summary, two tenants reviewed had unwitnessed falls outside on the patio in the courtyard, including Tenant #2 who sustained an injury. There were no staff present when the falls occurred and both falls were documented as unwitnessed. Tenant #2's service plan reflected hourly safety checks at night, a motion sensor while sleeping and he was not to be left unattended in his apartment during wake hours. It was noted he had an unsteady gait in October of 2020 and the PCP indicated he was not safe to ambulate on 7-27-21. Tenant #2 also had a history of falls, including a fall on 7-21-21 that resulted in a facial laceration and sutures. On 8-16-21 Tenant #2 was brought outside in a wheelchair by staff to the patio in the courtyard at 6:35 p.m. The next video observation of staff outside was at 7:04 p.m. (29 minutes later) and then at 7:06 p.m. Tenant #2 fell at 7:15 p.m. and laid on the ground without staff response for 11 minutes (7:15 p.m. to 7:26 p.m.). Tenant #2 sustained a laceration to the back of his head, was transported by ambulance to a hospital and received sutures. Staff had not been observed on video outside from 7:06 p.m. to 7:26 p.m. (20 minutes), including during the time period of Tenant #2's fall. There were other tenants observed on video also in the courtyard and without supervision from staff. Staff interviews revealed there were three staff on duty on 8-16-21 (second shift). During the time Tenant #2 and other tenants were seated outside on the patio, one staff was passing medications, one staff was assisting with a shower, and one staff | A 325 | | |

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| A 325 | Continued From page 10<br>provided toileting assistance and checked on the tenants. Two of three staff on duty were unaware of when Tenant #2 was last seen or checked on prior to his fall. Tenant #2, a tenant that was not safe to ambulate and had cognitive impairment, a fall history and interventions for safety related to falls while inside the building, was left unattended while outside in the courtyard. He fell and sustained an injury and laid on the ground for 11 minutes before staff responded. The Program did not provide sufficient staff to meet the needs of tenants, including Tenant #2. | A 325 | | |
| A 330 | 481-67.9(2) Staffing<br><br>67.9(2) Emergency procedures. All program staff shall be able to implement the accident, fire safety, and emergency procedures.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to ensure staff consistently implemented emergency procedures. This pertained to 1 of 2 tenants reviewed that were sent out to the hospital (Tenant #2). Findings follow:<br><br>Record review revealed an incident report indicated on 8-16-21 at 8:10 p.m. Tenant #2 was found outside on the concrete patio. Tenant #2 was seated in his wheelchair with other tenants after the evening meal. Staff went out to the patio and observed Tenant #2 on the ground and there was blood on the ground from his head. Tenant #2 was able to talk and held staff's hand. Staff called 911 and Tenant #2 was taken to a hospital. The nurse on call was also notified. Staff stayed with Tenant #2 until emergency services arrived | A 330 | | |

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and gave the paperwork to them. The incident report indicated there were no witnesses and that Tenant #2 sustained an laceration to the back of his head.

When interviewed on 8-24-21 at 4:35 p.m. Staff A said it was about 7:00 p.m. to 7:30 p.m. and she was passing medications. She let a visitor out of the building and saw Tenant #2 on the ground. There was blood on the concrete and he was laying on his side. He was bleeding from the back of the head. Tenant #2 had been seated in his wheelchair. She called other staff (Staff B and Staff C) for help. She said Tenant #2 was outside approximately 25 minutes and she did not know when he was last seen prior to finding him on the ground. She was passing medications and the other two staff were assisting with cares and showers. The Wellness Director was notified. The ambulance and fire department arrived. There were other tenants outside with Tenant #2; however, she was not was not able to recall how many tenants were on the patio. The door to the patio was open at that time. Tenants sat outside in the courtyard (weather permitting) without staff and staff checked on them. There were no timeframe required for the checks.

When interviewed on 8-25-21 at 9:17 a.m. Staff B said she worked second shift and after supper she took Tenant #2 outside to sit at 6:30 p.m. and then she went to give a shower. Tenant #2 was in his wheelchair and the wheelchair brakes were locked. Staff A was passing medications, Staff B was giving a shower and Staff C was in checking in on them and taking people to the bathroom. When Staff C checked on him he was sitting in his wheelchair. Staff B did not know when Tenant #2 was last checked on (prior to his fall) as she was giving a tenant a shower. Staff A called and

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| A 330 | Continued From page 12 | A 330 | | |

needed help. Tenant #2 was laying on his left side and his wheelchair was a little ways from him. Tenant #2 had a cut on his head, a towel was placed under his head and he was not moved. Staff called 911 and the Wellness Director was notified. Tenant #2 was taken to the hospital. She said there were eight tenants outside on the patio at that time and it was nice weather. Staff needed to be outside with the tenants or staff was to check on them. Staff C was back and forth checking on them.

When interviewed on 8-30-21 at 11:09 a.m. Staff C said she was working second shift and worked with Staff A and Staff B. After the evening meal staff took Tenant #2 and another tenant (also in a wheelchair) outside. Staff A was passing medications, Staff B was giving a shower and Staff C was taking tenants to the bathroom. Tenant #2 was taken outside to the patio between approximately 6:30 p.m. to 7:00 p.m. and was in his wheelchair. Tenant #2 was brought outside by either Staff A or Staff B. There was no staff sitting outside with the tenants and the door was open. Staff C was assisting with toileting other tenants and would come back and check on the tenants outside. Staff C said she checked on the tenants three to four times and they were doing okay and were sitting there. She had finished toileting another tenant and came out and saw Staff A and Staff B with Tenant #2 and they had called 911. When Staff C arrived Tenant #2 was laying on his side, a towel was placed under his head and he was responsive. Staff C said she had last checked on Tenant #2 approximately 10 minutes prior.

When interviewed on 8-25-21 the Wellness Director said she received a telephone call from staff that Tenant #2 had fallen on the patio. Staff

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| A 330 | Continued From page 13 | A 330 | | |

had called 911 and then called her. It appeared Tenant #2 was bleeding from the head and staff held pressure with a towel. She notified Tenant #2's family. Tenant #2 went to the hospital and returned the same day with sutures to back of his head. Tenant #2 had been sitting outside on the patio and appeared he tried to get up. There were no staff outside at the time and there other tenants outside. Staff A found him and then went to get help. She completed an employee coaching form with Staff B as she used her personal cellular phone to call 911 and not the landline. Staff B did not know where to find the exact address of the Program. She said it was approximately 30 minutes from when Tenant #2 fell until paramedics arrived.

When interviewed on 8-25-21 at 12:48 p.m. the Director said she was notified at 6:50 a.m. on 8-17-21 by the Wellness Director that Tenant #2 had fallen and went to the hospital. Tenant #2 got back at 11:30 p.m. on 8-16-21 and had received sutures. She was informed that Staff B used her personal cellular phone to call 911 and the Program's cordless phone should have been used. The Wellness Director said the paramedics were making a formal complaint that whoever called could not tell them the address.

Record review revealed Staff B had Wellness training completed on 7-20-21. The attached training information indicated topics covered included the Wellness training including emergency procedures and calling 911.

Record review revealed an Employee Coaching Form dated 8-17-21 was completed for Staff B. The description of the incident indicated during an incident on 8-16-21 a tenant had fallen outside and was found on the ground. Staff B notified

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| A 330 | Continued From page 14<br>called 911; however, Staff B used her personal cellular phone and not the Program's phone. Staff B received education on how to follow the procedure and where to find the correct Program's address to provide to emergency services. The Wellness Director and Staff B signed the form dated 8-17-21.<br><br>The Wellness Director provided a written statement regarding the verbal education provided to all caregivers and medication aides regarding the equipment they needed to carry. That equipment included: a Program cordless phone, nurse-call smart phone and a set of keys.<br><br>When interviewed on 8-25-21 at 5:39 p.m. and 9-15-21 at 3:44 p.m. the Wellness Director said when she went over the phones with staff, they were told any calls were to be made on the cordless (landline) phones. She said Staff B had trouble providing the correct Program address the dispatcher. A family member standing next to her assisted and provided the correct address to the dispatcher. | A 330 | | |
| A 395 | 481-69.26(4)a Service Plans<br><br>69.26(4) The service plan shall be individualized and shall indicate, at a minimum:<br><br>a. The tenant's identified needs and preferences for assistance<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the Program failed to have service plans reflect the identified needs of the tenants. This pertained to | A 395 | | |

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| A 395 | Continued From page 15<br>3 of 5 tenants reviewed (Tenants #2, #3 and #4). Findings follow:<br><br>1. Record review revealed an incident report indicated on 8-16-21 at 8:10 p.m. Tenant #2 was found outside on the concrete patio. Tenant #2 was seated in his wheelchair with other tenants after the evening meal. Staff went out to the patio and observed Tenant #2 on the ground and there was blood on the ground from his head. Tenant #2 was able to talk and held staff's hand. Staff called 911 and Tenant #2 was taken to a hospital. The nurse on call was also notified. Staff stayed with Tenant #2 until emergency services arrived and gave the paperwork to them. The incident report indicated there were no witnesses and that Tenant #2 sustained an laceration to the back of his head.<br><br>When interviewed on 8-24-21 at 4:35 p.m. Staff A said it was about 7:00 p.m. to 7:30 p.m. and she was passing medications. She let a visitor out of the building and saw Tenant #2 on the ground. There was blood on the concrete and he was laying on his side. He was bleeding from the back of the head. Tenant #2 had been seated in his wheelchair. She called other staff (Staff B and Staff C) for help. She said Tenant #2 was outside approximately 25 minutes and she did not know when he was last seen prior to finding him on the ground. She was passing medications and the other two staff were assisting with cares and showers. The Wellness Director was notified. The ambulance and fire department arrived. There were other tenants outside with Tenant #2; however, she was not was not able to recall how many tenants were on the patio. The door to the patio was open at that time. Tenants sat outside in the courtyard (weather permitting) without staff and staff checked on them. There | A 395 | | |

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were no timeframe required for the checks.

When interviewed on 8-25-21 at 9:17 a.m. Staff B said she worked second shift and after supper she took Tenant #2 outside to sit at 6:30 p.m. and then she went to give a shower. Tenant #2 was in his wheelchair and the wheelchair brakes were locked. Staff A was passing medications, Staff B was giving a shower and Staff C was in checking in on them and taking people to the bathroom. When Staff C checked on him he was sitting in his wheelchair. Staff B did not know when Tenant #2 was last checked on (prior to his fall) as she was giving a tenant a shower. Staff A called and needed help. Tenant #2 was laying on his left side and his wheelchair was a little ways from him. Tenant #2 had a cut on his head, a towel was placed under his head and he was not moved. Staff called 911 and the Wellness Director was notified. Tenant #2 was taken to the hospital. She said there were eight tenants outside on the patio at that time and it was nice weather. Staff needed to be outside with the tenants or staff was to check on them. Staff C was back and forth checking on them.

When interviewed on 8-30-21 at 11:09 a.m. Staff C said she was working second shift and worked with Staff A and Staff B. After the evening meal staff took Tenant #2 and another tenant (also in a wheelchair) outside. Staff A was passing medications, Staff B was giving a shower and Staff C was taking tenants to the bathroom. Tenant #2 was taken outside to the patio between approximately 6:30 p.m. to 7:00 p.m. and was in his wheelchair. Tenant #2 was brought outside by either Staff A or Staff B. There was no staff sitting outside with the tenants and the door was open. Staff C was assisting with toileting other tenants and would come back and check on the tenants

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outside. Staff C said she checked on the tenants three to four times and they were doing okay and were sitting there. She had finished toileting another tenant and came out and saw Staff A and Staff B with Tenant #2 and they had called 911. When Staff C arrived Tenant #2 was laying on his side, a towel was placed under his head and he was responsive. Staff C said she had last checked on Tenant #2 approximately 10 minutes prior.

When interviewed on 8-25-21 the Wellness Director said the courtyard doors were locked unless opened by staff. The door could be left open and it was treated like the interior, as the courtyard was gated and secured. That occurred often, weather permitting. She said it was like other areas of the building, tenants could be unattended and the checks would vary depending on safety checks and toileting checks.

Continued record review of Tenant #2's file revealed a diagnosis of dementia with behavioral disturbance. Tenant #2 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline and he received hospice services. The most current service plan (not signed or dated) indicated Tenant #2 used a wheeled walker for an assistive device. Staff was to provide verbal prompting and encouragement as needed. Tenant #2 might require prompting on how to safely "navigate" throughout the building. Tenant #2 might be at risk for falls, he required occasional assistance of one person and staff to help stand up and was otherwise independent. Tenant #2 had routine safety hourly safety checks at night. The service plan reflected Tenant #2 would not be left unattended in his apartment during wake hours and the bedroom door was locked during wake

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hours. When Tenant #2 was napping or sleeping at night a motion senor was used. Staff would monitor the environment for safety when ambulating and transferring. Staff charted every two hours that the protocol was being upheld.

Further record review revealed incident reports indicated Tenant #2 had falls on 5-30-21, 6-10-21, 6-12-21 and 7-21-21. On 7-21-21 Tenant #2 was found on the floor of the theatre room next to his wheelchair, laying on his left side. Tenant #2's family member was with him, left for a brief time and returned to find him on the ground. Tenant #2 had a small laceration above the left eye and it was determined sutures would be needed. Tenant #2 was transported to a hospital for evaluation.

Continued record review revealed a Long Term Care Facility Acute Visit document (encounter date 7-27-21) completed by the primary care provider (PCP) indicated Tenant #2 was seen for an acute visit, after being evaluated in the ER on 7-21-21 for a fall and facial laceration. For recurrent falls the "Assessment & Plan" indicated to use a wheelchair for mobility as Tenant #2 was "no longer able to safely ambulate." Tenant #2 had a history of falls with bilateral hip fractures.

Further record review revealed Tenant #2's current service plan did not reflect interventions in place for Tenant #2's safety while in the courtyard. It also did not reflect the PCP's recommendations regarding ambulation and the use of a wheelchair.

2. Record review of an incident report dated 8-17-21 at 1:00 p.m. revealed Tenant #3 was found on the ground outside on the patio. Tenant #3 was able to get up and denied pain. Tenant #3

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said he tripped and fell on the ground. There were no injuries. The report indicated there were no witnesses.

Continued record review of Tenant #3's file revealed diagnoses included: Alzheimer's dementia without behavioral disturbance and Parkinson's disease. Tenant #3 was staged at a five on the GDS, which indicated moderate cognitive decline. The service plan (not dated or signed) indicated Tenant #3 might be at risk for falls, staff was to monitor for transfer and safety techniques and provided cueing as needed. A gait belt was to be used all times when staff assisted Tenant #3 with ambulation and transfers. Staff was to cue and provide verbal prompting as needed and hands-on assistance when needed for transfers. Tenant #3 received two hour safety checks at night and had a motion sensor in his apartment that was activated from 8:00 p.m. to 7:00 a.m. to ensure he was assisted when the motion senor went off.

Further record review revealed the Resident Assessment Form dated 10-26-20 reflected occasional assistance for transfers and to monitor and cue to use his walker.

Continued record review revealed Tenant #3's current service plan did not reflect Tenant #3's assistive device (walker).

3. Record review on 8-24-21 of Tenant #4's file revealed diagnoses included: early onset Alzheimer's dementia without behavioral disturbance. Tenant #4 was staged at a four on the GDS, which indicated early cognitive decline.

Physician Fax Communication documents reflect the following:

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| A 395 | Continued From page 20<br><br>-On 8-4-21 it was noted since Tenant #4 moved in he had become "increasingly anxious, restless, constantly wanted to leave." He carried his belongings around most of the day and had become harder to redirect.<br><br>-On 8-8-21 it was noted Tenant #4 had been "very agitated" since moving in, was redirectable, but "constantly" was exit seeking. Quetiapine 50 milligram, three times per day as needed was ordered.<br><br>Further record review revealed Tenant #4's current service plan did not address the behaviors noted above, including exit seeking and agitation and interventions related to the behavior. The wandering section on the service plan indicated Tenant #4 was independent.<br><br>4. When interviewed on 8-25-21 and 9-15-21 at 3:44 p.m. the Wellness Director confirmed the most recent service plans were provided the tenants were provided. She confirmed Tenant #2's service plan did not reflect supervision while outside. She said if Tenant #4's service plan reflecting exit seeking, it would under the wandering section on the service plan. | A 395 | | |
| A 635 | 481-69.32(2) Life Safety - Emergency Policies / Structure<br><br>69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record | A 635 | | |

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| A 635 | Continued From page 21<br>review the Program failed to ensure an operating door alarm system was connected to connected to each exit door. This potentially affected all tenants (census of 26). Findings follow:<br><br>Observation on 8-25-21 at 2:40 p.m. revealed a door from the interior of the building to the courtyard was propped open.<br><br>Record review revealed the Program's Security policy and procedure indicated in a secured area all exit doors and courtyard gates would "always" be secured.<br><br>When interviewed on 8-24-21 at 4:35 p.m. Staff A said Tenants sat outside in the courtyard (weather permitting) without staff and staff checked on them. There were no timeframe required for the checks.<br><br>When interviewed on 8-24-21 at 3:10 p.m. Staff D reported if it was nice outside, the patio was open and tenants would come and go. It was secured outside. She said checked on them when walking by and 90% of the time staff were outside with tenants.<br><br>When interviewed on 8-25-21 the Wellness Director said the courtyard doors were locked unless opened by staff. The door could be left open and it was treated like the interior, as the courtyard was gated and secured. That occurred often, weather permitting. She said it was like other areas of the building, tenants could be unattended and the checks would vary depending on safety checks and toileting checks.<br><br>When interviewed on 8-25-21 at 12:48 p.m. the | A 635 | | |

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| A 635 | Continued From page 22<br>Director said the tenant enjoyed being in the courtyard and it was healthy for them. When tenants were outside the door was propped open and staff was to keep an eye on the tenants as they would if they were sitting in the common area. Checks were completely similarly, when a tenant was inside or outside. The door to the courtyard had a battery back up, which was a secondary alarm. It was turned off and on when the patio door was opened and closed. No other doors to the courtyard were left open and the gates to the courtyard were secured. | A 635 | | |

OK 2/15/22

CountryHouse Cedar Rapids

Plan of Correction

The preparation of the following plan of correction for the regulatory insufficiencies cited during the initial certification visit between 8/23/21 to 9/15/21 does not constitute and should not be interpreted as an admission nor an agreement by the program of the truth of the facts alleged or conclusions set forth in statements of regulatory insufficiencies. The plan of correction prepared for these insufficiencies was executed solely because provisions of State law require it.

67.9(1) Staffing

Regulatory Insufficiency: Based on observation, interview and record review the Program failed to provide adequate supervision to tenants on the outside patio. This pertained to 2 of 2 tenants reviewed that fell outside in the courtyard (Tenants #2 and #3). This potentially affected all tenants (census of 26).

Plan of Correction:

**The insufficiency will be corrected as follows:**

1. A Courtyard Supervision policy was developed that specifies that staff will accompany residents and/or visually monitor the courtyard every 15 minutes while occupied.
2. Residents who require closer supervision while in the courtyard will have a notation on their service plan to inform and direct staff of supervision needs.

**The following measures will be taken to ensure the problem does not recur:**

All tenants will either be accompanied in the courtyard as indicated in their service plan or visually monitor the courtyard every 15 minutes while occupied.

**The program will monitor performance to ensure compliance as follows:**

All staff will be provided training on the new Courtyard Supervision policy, and annually thereafter. Only those authorized by the program will have credentials to open a secured door.

**Date Insufficiency corrected:**

Insufficiency corrected on 8/27/21.

481-69.26(4)a Service Plans

Regulatory Insufficiency: Based on interview and record review the Program failed to have service plans reflect the identified needs of the tenants. This pertained to 3 of 5 tenants reviewed (Tenants #2, #3 and #4)

**Plan of Correction:**

The insufficiency will be corrected as follows:

1. Tenant #2 no longer resides in the community.
2. Tenant #3 service plan was updated on 10/28/21 to reflect use of assistive device (walker).
3. Tenant #4 service plan was updated on 10/28/21 to reflect tenant's agitation and exit seeking, and interventions for staff.

**The following measures will be taken to ensure the problem does not recur:**

1. n/a
2. Wellness Coordinator RN will ensure service plan reflects all the elements of the assessment.
3. Wellness Coordinator, RN will update the service plan when incidences or changes in condition/nurse review indicate new interventions or other changes to the service plan are warranted.

**The program will monitor performance to ensure compliance as follows:**

1. Wellness coordinator will ensure that care plans are updated appropriately to reflect changes in assessment or nurse review. Program Manager will review service plans and assessments monthly to ensure compliance.
2. Service plans will be updated with interventions and strategies for staff to reflect tenants' changes in behaviors.
3. Wellness Coordinator RN will ensure that service plans are updated appropriately to reflect interventions associated with incident reports.

**Date Insufficiencies corrected: 10/28/21**

481-69.32(2) Life Safety

Regulatory Insufficiency: Based on observation, interview and record review, the Program failed to ensure an operating door alarm system was connected to each exit door. This potentially affected all tenants (census of 26).

**Plan of Correction:**

The insufficiency will be corrected as follows:

1. As of 8/27/21, the door to the courtyard patio area is no longer permitted to be propped open for tenants to be able to enter and exit the courtyard at will. All exit doors will be engaged by a locking mechanism at all times.

**The following measures will be taken to ensure the problem does not recur:**

New Courtyard Supervision policy was put in place to ensure all doors are to be engaged by a locking mechanism at all times, and only those authorized by the program will have credentials to open a secured door.

**The program will monitor performance to ensure compliance as follows:**

All locking doors are checked for security at each shift change.

**Date Insufficiency corrected: 8/27/21**

Signature

11/3/21

Date