

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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: 7 Number of tenants with cognitive disorder: 0  Memory Care Unit Number of tenants without cognitive disorder: 11 Number of tenants with cognitive disorder: 5  TOTAL Census of Assisted Living Program for People with Dementia: 22  The investigation of Complaints #98826-C, #103064-C, #103226-C and #105759-C and the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program were completed. The following regulatory insufficiencies were identified:	A 000			
A 145	481-69.22(3) Evaluation of Tenant  69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a	A 145			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 145	<p>Continued From Page 1</p> <p>significant change.</p> <p>This Requirement is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 2 of 3 current tenants reviewed (Tenants #1, and #3) and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow:</p> <p>1. Record review on 7-26-22 of Tenant #1's file revealed an incident report dated 7-3-22 indicated staff went into Tenant #1's apartment and observed her on the floor. Tenant #1 was on her back near the door and did not use her walker. Tenant #1 said she hit her head and was "experiencing significant back pain." Tenant #1 was transported to the hospital via ambulance.</p> <p>Further record review revealed an After Visit Summary (hospital document) dated 7-3-22 indicated the reason for the visit was a fall with new back pain and arm pain. The diagnosis listed was a "Closed compression fracture of L4 lumbar vertebrae, initial encounter (HCC)."</p> <p>Continued record review revealed evaluations were not completed following Tenant #1's fall, ER visit and diagnosis of compression fracture.</p> <p>2. Record review on 8-2-22 of Tenant #3's file revealed Progress Notes documented on 7-15-22 a fax was sent to the PCP related to Tenant #3's difficulty "swallowing/cough/vomiting while eating." The PCP was also notified about an area to her heel. An order was received for a video pharyngogram. On 8-1-22 it was noted a voicemail was left for Tenant #3's family regarding the swallow study.</p>	A 145			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 145	Continued From Page 2  Continued record review revealed a Fax Cover Sheet to the PCP dated 7-11-22 indicated staff reported Tenant #3 was vomiting with meals. It was a request for a speech therapy referral or other orders. It was also noted Tenant #3 had a sore to the right heel. She was going to be seen by a podiatrist on 7-15-22 and it was covered with a triple antibiotic ointment and bandage until then. The sore "is pinpoint center with half in circle surrounding." The PCP responded with several questions including if she had trouble swallowing, clarified if she was coughing or vomiting and asked how long the sore had been there. It was communicated back to the PCP, that Tenant #3 had difficulty swallowing, coughed and vomited. She was not sure how long the sore had been there. A video pharyngogram was ordered.  Further record review revealed the most recent Comprehensive Assessment was dated 1-11-22. Evaluations were not completed as needed with Tenant #3's difficulty swallowing, coughing and vomiting while eating and the area on Tenant #3's heel.  3. a. Record review on 7-26-22, 8-1-22 and 8-2-22 of Tenant C2's file revealed an incident report dated 10-19-21 at 7:30 p.m. indicated staff went to give Tenant C2 her evening medications and found her on the floor "moaning, crying, complaining of back and chest pain." Staff called the nurse and due to Tenant C2's "extreme pain" the nurse told staff to call the non-emergency ambulance and have Tenant C2 transported to the hospital. An After Visit Summary from the hospital dated 10-19-21 indicated the reason for the ER visit was a fall and diagnoses included fall and closed fracture of multiple ribs (left side). Tenant C2 returned with orders for Percocet 5/325	A 145			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 145	Continued From Page 3  milligram (mg), one tablet every six hours as needed for pain, pulse oximetry checks twice daily, incentive spirometer three times daily for seven days, ambulate two to three times per day and to return for trouble breathing, increased pain, increased confusion or concerns.  -Additional record review revealed Progress Notes on 10-24-21 noted staff called a nurse and reported Tenant C2 had been shaky that shift and had recently fractured ribs. It was requested that staff obtain vital signs and call the nurse back. An additional note on 10-24-21 indicated staff called the nurse back and vital signs were as follows: temperature 97.8, blood pressure was 140/82, pulse was 78 and oxygen saturation started at 92% when staff put the oximeter on but it dropped to 88% and 87%. Staff was instructed to give her pain medication and the nurse would contact the family to see if they wanted anything else done. Tenant C2's family member was contacted regarding her being shaky and low oxygen saturation. Family declined to have her sent out at that time. It was decided to administer the pain medication and monitor Tenant C2's oxygen saturation throughout the night.  Continued record review revealed a Long Term Care Facility Acute Visit dated 10-25-21 indicated she fell on Tuesday night and was transferred to the hospital. Tenant C2 had some rib fractures. She was "now much more reliable on staff and her husband for care. She was unable to ambulate due to the pain. She needs assistance for feeding from staff and/or her husband." When observed she was in her apartment and appeared to be in "quite a bit of pain." Staff monitored her oxygen saturation every four hours which was lower than normal. Based on the increased care and falls level of care was discussed with Tenant C2's family and the nurse. A Provider Order Sheet	A 145			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 145	Continued From Page 4  dated 10-25-21 indicated orders for lidocaine 4%, on for 12 hours and off for 12 hours and Lortab 5/325 mg, orally, every 4 hours as needed for rib fractures.  b. Additional record review revealed Progress Notes documented on 10-29-21 a fax was sent to Tenant C2's PCP regarding a wound on the right foot. An order was received to apply Mepilex and change every other day. On 11-4-21 it was noted staff called the nurse on-call to inform her of an open blister on Tenant C2's buttocks. The nurse assessed Tenant C2 and noted an open blister to the right buttock. The area measured 6 centimeters (cm) x 4.5 cm. There was also an area of skin that was dark purple and non-blanchable to the "upper coccyx split." Mepilex border was applied over the area on the right buttocks.  When interviewed on 7-21-22 at 5:02 p.m. Staff I said Tenant C2 refused to be repositioned and staff attempted. She said it got to the point that staff could not do anything with her and she would get aggressive. Staff tried to "flip her" and used a pillow (regarding repositioning her). Tenant C2 needed two people for transfers. She sat in her recliner in her apartment and staff tried to put a pillow on each side and Tenant C2 refused. Tenant C2 slept in the recliner too. Staff I did not identify any current or discharged tenants with a pressure wound.  When interviewed on 7-25-22 at 12:05 p.m. Staff J said Tenant C2 had a pressure sore on her buttocks and it was first treated with a cream and then a pad was put on it. She said Tenant C2 had fractured her ribs, could not stand well and staff were holding her up. After the rib fracture she was mostly a two person assist. Staff did one	A 145			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 145	<p>Continued From Page 5</p> <p>hour checks to reposition her and she was in the chair in her apartment. Tenant C2 was agreeable to be repositioned sometimes and at other times she had taken the pillow out. She was not able to get out on her own at that point. She received tray meals in the apartment and she could get aggressive. After the rib fracture staff did their best regarding toileting and she was changed in her chair. She was combative towards staff. Staff provided sponge baths after her rib fracture.</p> <p>When interviewed on 7-25-22 at 1:00 p.m. Staff K said Tenant C2 had to be repositioned and she was resting in her chair. Staff would sit in her apartment and feed her and she received a sponge bath. For toileting Tenant C2 took two people to assist. Staff K did not identify any current or discharge tenants with a pressure wound.</p> <p>c. Review of Tenant C2's unsigned service plan, dated 7-16-21, the service plan reflected Tenant C2 needed reminders/cues for toileting, staff checked her protective undergarment and changed it if soiled. If the bandage on her buttocks was peeled staff was to replace it with a silicone bandage. Tenant C2 had a daily wound dressing on the right buttock with Mepilex border. Tenant C2 was an assist of one person. The service plan was not updated when Tenant C2 returned from the hospital after multiple rib fractures and with new orders, required increased care needs and supervision, changes with ambulation and transfers and discussion regarding a needing a higher level of care. The service plan also did not reflect Tenant C2's pain and interventions and to monitor her breathing and oxygen saturation. The service plan was not updated timely to reflect new wounds to her foot and buttocks which were staged at a II (foot) and III (sacral area). The service plan was also not</p>	A 145			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 145	Continued From Page 6  updated as needed to reflect the worsening of the coccyx wound. There was a 25 pound weight loss from the time of the rib fractures until she returned to the hospital on 11-12-21 and the service plan did not reflect weight loss or increased assistance needed with eating.  Continued record review revealed cognitive, health and functional evaluations were completed on 7-16-21. The next completed Comprehensive Assessment had an effective date of 11-4-21 but was not locked (electronic record) and signed until 11-11-21. Evaluations were not completed as needed including when Tenant C2 returned from the hospital after multiple rib fractures and with new orders, with increased care needs and supervision, changes with her ambulation and transfers and discussion regarding Tenant C2 needing a higher level of care. Evaluations were also not completed when Tenant C2's as needed pain medications were documented as not effective (all but one administration) and Tenant C2's oxygen saturation dropped below 90% (12 times). Evaluations were also not completed as needed with new wounds to her foot and buttocks, which were staged at a II (foot) and III (sacral area). There was also a 25 pound weight loss from the time of the rib fractures until she returned to the hospital on 11-12-21 and evaluations were not completed.  5. When interviewed on 8-2-22 at 3:31 p.m. the Clinical Care Specialist confirmed all evaluations were provided for the tenants listed above.	A 145			
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.	A 150			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 150	Continued From Page 7  This Requirement is not met as evidenced by: Based on interview and record review the Program failed to follow established policies and procedures related to incident reports. This pertained to 1 of 3 of current tenants reviewed (Tenants #1) and 2 of 2 discharged tenants reviewed (Tenants C1 and C2). Findings follow:  1. a. Record review on 7-26-22 and 8-1-22 revealed Tenant C1's file included the following: Progress Notes included a progress note on 11-2-21 noted staff observed Tenant C1 laying on the floor on her right side. Tenant C1 said she had fallen off of the bed. A small excoriated area was noted on Tenant C1's eyebrow. Family was contacted and declined an evaluation in the ER. Tenant C1 was assisted back to bed. A fax cover sheet from 11-2-21 noted Tenant C1 had a fall out of bed and had a small rug-burn on her right eyebrow. Progress noted further documented on 11-3-21 Tenant C1 denied pain from the fall. The excoriated area on the right eyebrow was observed. A fax coversheet from 11-3-21 noted Tenant C1 had another fall out of bed. She had two falls in 24 hours. Tenant C1 was able to ambulate but was weak. A fax from the PCP received 11-3-21 in response to Tenant C1's fall noted "psych meds are likely cause of falls" and ordered lab work.  Continued record review revealed an incident report was found dated 11-2-21 at 12:00 p.m. Staff found Tenant C1 laying on her right side on the right side of her bed. Tenant C1 said she fell out of bed. A small excoriated area was noted on the Tenant C1's right eyebrow. Tenant C1 was assisted back to bed. An incident report was not found related to the second fall in 24 hours as noted in the fax to the PCP.  b. Record review on 7-26-22, 8-1-22 and 8-2-22	A 150			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 150	<p>Continued From Page 8</p> <p>of Tenant C2's file revealed an incident report dated 10-19-21 at 7:30 p.m. documented staff went to give Tenant C2 her evening medications and found her on the floor. Tenant C2 was "moaning, crying, complaining of back and chest pain." Staff called the nurse and due to Tenant C2's "extreme pain" the nurse told staff to call the non-emergency ambulance and have Tenant C2 transported to the hospital. An After Visit Summary from the hospital dated 10-19-21 indicated the reason for the ER visit was a fall and diagnoses included fall and closed fracture of multiple ribs (left side).</p> <p>Continued record review revealed the incident report was completed by the Former Healthcare Coordinator #1; however, an incident report completed by the staff on shift when the incident occurred was not found. An Incident Audit Report indicated the report was created on 10-20-21 and the document was not locked until 11-9-21. The incident report was locked by the Director, and not the Former Healthcare Coordinator #1, who had created the document.</p> <p>Record review of the Program's incident report policy and procedure indicated staff would notify the nurse if a tenant had fallen or any unusual event occurred. An incident report would be completed by the nurse or designee. The nurse or designee would indicated a person in charge on to fill out the report in their absence. When an incident report was completed it would be factual and to the point. It would be signed with time and date. Witnesses of the incident would provide a factual statement. The report would be turned into the nurse. The nurse was responsible to follow up with a review of reportable incidents and enter them into the electronic system. Paper forms (handwritten) were kept for three years and electronic forms were kept indefinitely.</p>	A 150			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 150	<p>Continued From Page 9</p> <p>2. Record review on 7-26-22 revealed an incident report for Tenant #1 dated 3-12-22 at 5:11 p.m. reflected staff walked out of the elevator on third floor and observed Tenant #1 laying on her right side on the dining room floor. Tenant #1 did not hit her head and was not sure why or how she fell. Tenant #1 wanted to get up off of the floor. Tenant #1 complained of pain to her head. Emergency medical services (EMS) were called and responded. They assisted Tenant #1 off of the floor and took her to the ER. The incident report noted Tenant #1's family member was notified on 3-12-22 at 7:00 p.m.</p> <p>Continued record review of hospital documents indicated Tenant #1 arrived on 3-12-22 at 5:50 p.m. Hospital documents indicated she had a fall and possible head trauma. Tenant #1 did not remember the fall and had no complaints. The document indicated "She did not want to come in. Has no complaints. Denies headache, neck pain, back pain or any extremity pain." The hospital diagnosis was a fall (initial encounter) and dementia without behavioral disturbance. No changes were made to her medications.</p> <p>Further record review revealed the Prehospital Care Report Summary indicated the ambulance was called at 5:16 p.m., arrived at 5:25 p.m. and left at 5:40 p.m. When EMS arrived staff reported Tenant #1 had an unwitnessed fall and had injuries to her right arm, neck and right leg. EMS observed Tenant #1 laying on her left side on the floor. Tenant #1 was alert, had no obvious bleeding or deformities. Tenant #1 had no pain and said she had no injuries. Tenant #1 reported she did not hit her head and she did not want to go to the hospital. Vital signs were taken and were within the normal limits. The report noted, "IT WAS DEEMED ACCEPTABLE FOR THE</p>	A 150			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 150	Continued From Page 10  PATIENT TO REFUSE CARE." Staff reported they could not reach Tenant #1's legal representative. Tenant #1 was assisted up to a chair and was steady on her feet. The report noted staff told Tenant #1 her family member wanted her to be transported, but "... THERE WAS NO EVIDENCE OF THIS PHONE CALL." The report further noted Tenant #1 "...THEN DECIDED TO GO TO THE HOSPITAL."  Continued record review revealed the Program's policy and procedure for Emergency Transfer indicated if a tenant needed emergency transfer, the nurse or direct care staff would arrange for a transfer via ambulance to the hospital designated. "All transfers are coordinated with the input of the Designated Responsible Person as to the time and location of the transfer."  The Medical Illness/Crisis Intervention Plan policy and procedure indicated if a tenant needed medical assistance, 911 would be called or advance directives would be followed. The family would be contacted "immediately."  When interviewed on 8-2-22 at 3:31 p.m. the Clinical Care Specialist confirmed a tenant's family should be notified right away unless they told the Program of incidents they did not want to be notified of or times they did not want to be notified.	A 150			
A 160	481-67.3(2) Tenant Rights  481-67.3 Tenant rights. All tenants have the following rights:  67.3(2) To receive care, treatment and services which are adequate and appropriate.	A 160			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 160	Continued From Page 11  This Requirement is not met as evidenced by: Based on interview and record review the Program failed to ensure tenants received housekeeping and laundry services as indicated in the occupancy agreement. This potentially affected all tenants (census of 22). Findings follow:  A community meeting with four tenants was held on 7-21-22. The tenants voiced concerns regarding laundry and not getting their items returned to them. One tenant said she told her family to get a specific color of sheets so they were recognized as her linens and would be returned. The issue with laundry was routine in nature according to the tenants. One tenant said she did not receive weekly housekeeping services and said it would be nice if it was provided.  Review of housekeeping logs for May 2022 indicated first floor (AL) had four documented dates in May for apartment cleans: 5-4-22, 5-11-22, 5-18-22 and 5-25-22. Second floor (closer care) had three documented dates in May for apartment cleans: 5-5-22, 5-12-22 and 5-19-22. Third floor (memory care) had three documented dates in May for apartment cleans: 5-6-22, 5-13-22 and 5-20-22.  Housekeeping logs for June 2022 indicated first floor (AL) had four documented dates in June for apartment cleans: 6-10-22, 6-16-22, 6-23-22 and 6-30-22. From the last time the first floor apartments were cleaned in May to first time in June was 15 days. Second floor (closer care) had three documented dates in June for apartment cleans: 6-11-22, 6-17-22 and 6-24-22. From the last time second floor apartments were cleaned in May to the first time in June was 22 days. Third floor (memory care) had one documented	A 160			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 160	<p>Continued From Page 12</p> <p>date in June for apartments cleans on 6-21-22. From the last time third floor apartments were cleaned in May until the first time in June it was over one month.</p> <p>Housekeeping logs for July 2022 indicated first floor (AL) had three documented dates in July for apartments cleans: 7-6-22, 7-20-22, 7-27-22. Second floor (closer care) had four documented dates in July for apartment cleans: 7-1-22, 7-7-22, 7-21-22 and 7-28-22. Third floor (memory care) had three documented dates for apartment cleans: 7-8-22, 7-22-22 and 7-30-22. From the last time third floor apartments were cleaned in June to the first time in July was 16 days.</p> <p>Continued record review revealed the Occupancy Agreement indicated Assisted Living Program services included personal laundry (two loads weekly) and a weekly change of linens and weekly housekeeping (30 minutes per apartment).</p> <p>When interviewed on 7-25-22 at 1:00 p.m. Staff K said the direct care staff did the laundry for third floor (memory care) as needed and there was no scheduled day.</p> <p>When interviewed on 7-25-22 at 12:05 p.m. Staff J said the laundry staff completed laundry for first floor and the direct care staff completed personal laundry for second and third floors. She said the housekeeping staff was out for awhile in the past month.</p> <p>When interviewed on 8-2-22 at 3:31 p.m. the Clinical Care Specialist said she had spoken with the Director regarding putting the housekeeping records into the electronic charting system. She said she had not received tenant complaints regarding housekeeping and laundry.</p>	A 160			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 285	Continued From Page 13	A 285			
A 285	<p>481-67.5(2)f(4) Medications</p> <p>67.5(2) Each program shall follow its own written medication policy, which shall include the following:</p> <p>f. When medications are administered traditionally by the program:</p> <p>(4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.</p> <p>This Requirement is not met as evidenced by: Based on interview and record review the Program failed to administer medications and complete treatments per physician order. This pertained to 2 of 3 current tenants reviewed (Tenants #2 and #3) and of 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow:</p> <p>1. Record review on 7-25-22 and 7-26-22 of Tenant #2's file revealed the April 2022 medication administration records (MARs) included lidocaine pad 5%, one patch applied topically daily (apply at 8:00 a.m. and remove at 8:00 p.m.). Further review revealed the medication was not documented as completed 11 times from 4-15-22 to 4-21-22 and the charting indicated a "9" which was "Other/See Progress Notes."</p> <p>Continued record review revealed Progress Notes from 4-16-22 to 4-21-22 indicated the medication was not available to administer. On 4-17-22 it was charted as a refusal; despite the medication not being available to administer.</p> <p>Review of June 2022 MARs reflected on 6-25-22 and 6-30-22 at 8:00 p.m. lidocaine pad 5%, one patch applied topically daily (apply at 8:00 a.m.</p>	A 285			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 285	Continued From Page 14  and remove at 8:00 p.m.) was not documented as completed. The entries on the MARs were incomplete and did not reflect the patch was removed. On 6-25-22 and 6-30-22 at 8:00 p.m. quetiapine 25 milligram (mg) tablet, take one tablet, orally, twice daily, was not documented as administered. On 6-30-22 at 5:00 p.m. warfarin 5 mg tablet, take one tablet, orally, daily on Monday, Tuesday, Thursday, and Saturday was not documented as administered. On 6-25-22 and 6-30-22 at 8:00 p.m. Vitamin D 25 microgram (mcg), take one tablet, orally, at bedtime, was not documented as administered.  2. Record review of Tenant #3's file on 8-2-22 revealed the June 2022 MARs reflected hydrocodone/APAP 5/325 mg one tablet every morning at 8:00 a.m. was not administered from 6-6-22 to 6-9-22 and the charting indicated a "9" which was "Other/See Progress Notes."  Continued record review revealed Progress Notes from 6-6-22 to 6-9-22 indicated the medication was not in the cabinet.  Review of July MARs revealed hydrocodone/APAP 5/325 mg, one tablet every morning at 8:00 a.m. was not administered on 7-25-22 and the charting indicated a "9" which was "Other/See Progress Notes." The Progress Note dated 7-25-22 indicated the medication was not in the cabinet.  Continued review of July MARs revealed Toujeo Solo insulin, 70 units injected subcutaneously daily at 8:00 a.m., reflected a "10" which indicated "Partial Administration" and 23 units were recorded. Progress Notes dated 7-22-22 indicated Tenant #3 received 23 units of Toujeo and not 70 units (as prescribed) due a new insulin pen not being available. The insulin pen was	A 285			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 285	<p>Continued From Page 15</p> <p>ordered from the pharmacy on 7-8-22 and the pharmacy said it was ordered too soon. It would be arriving from pharmacy that night.</p> <p>3.a. Record review on 7-26-22, 8-1-22 and 8-2-22 of Tenant C2's file revealed an incident report dated 10-19-21 at 7:30 p.m. documented staff found Tenant C2 on the floor "moaning, crying, complaining of back and chest pain." Staff called the nurse and due to Tenant C2's "extreme pain" the nurse told staff to call the non-emergency ambulance and have Tenant C2 transported to the hospital. A document from the hospital, signed by the attending physician, dated 10/19/21 2245 (10:45 p.m.) noted a diagnosis of multiple left sided rib fractures. The document further ordered: Percocet 5/325 milligram (mg), one tablet every six hours as needed for pain, pulse oximetry checks twice daily, incentive spirometer three times daily for seven days, ambulate two to three times per day and to return for trouble breathing, increased pain, increased confusion or concerns.</p> <p>Further record review revealed the October 2021 MARs did not reflect the orders or completion of the orders from the ER post rib fractures including: the incentive spirometer three times daily for seven days and to ambulate to to three times per day. Additional record review revealed from 10-24-21 to 10-31-21 there were seven times Tenant C2's oxygen was less than 90%.</p> <p>b. Record review revealed Tenant C2's Progress Notes revealed the following: - Progress Notes documented on 10-29-21 a fax was sent to Tenant C2's primary care provider (PCP) regarding a wound on the right foot. An order was received to apply Mepilex and change every other day. Review of the fax cover sheet confirmed the PCP</p>	A 285			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 285	<p>Continued From Page 16</p> <p>was made aware Tenant C2 had a large blister on the bottom of her right foot on 10-29-21 and some tenderness and redness on the one side. An order was received to cover the blister with Mepilex and change every other day and monitor for redness.</p> <p>- Progress notes documented on 11-5-21 the PCP was made aware Tenant C2's blister on her right foot had burst, she had some bruising and it was covered with Mepilex. A new large blister was noted on the right buttocks, which measured 6 cm x 4.5 cm. Mepilex border was applied and the area was red and "blister skin peeling." A small area of dark purple non-blanchable skin was noted just at the "coccyx slit."</p> <p>-On 11-11-21 it was noted the PCP was made aware Tenant C2's wound on the "upper coccyx slit" was getting larger. She also had a popped blister wound on the right buttocks. The fax indicated "Concerned about worsening." It indicated Tenant C2 was still able to ambulate with assist of one to the bathroom. Staff applied the Mepilex border to the buttocks wound but were unable to dress the coccyx pressure area. It was requested for her to be seen or a referral to the wound clinic. An order was received to refer her to the wound clinic.</p> <p>Continued record review revealed hospital records Tenant C2 was sent to the ER and was admitted to the hospital on 11-12-21. It was noted Tenant C2 was sent for an evaluation related to low oxygen saturation. Her oxygen saturation level was as low as 79%. Tenant C2 was "Initially on 15 L by nonrebreather mask and were able to get her off of oxygen after repositioning her." The records further noted, "... Nursing staff found 2 decubitus ulcers, one on the sacrum estimated to be a stage III and one on the right bottom of the foot, stage II.</p>	A 285			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 285	Continued From Page 17  I am concerned that she is not receiving adequate supervision to encourage her to ambulate given the findings of these 2 ulcers."  The November 2021 Documentation Survey Report listed a task to check Tenant C2's protective undergarment and change it if soiled. If the bandage on her buttocks was peeled to replace it with a silicone bandage in the medication cabinet. October and November 2021 MARs did not reflect the treatment order or the completion of the treatment order for Tenant C2's foot wound. The November 2021 MARs did not reflect the order or the completion of the treatment order for Tenant C2's buttock wound.  4. When interviewed on 8-2-22 at 3:31 p.m. the Clinical Care Specialist confirmed all orders and MARs for the tenants listed above were provided.	A 285			
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 2 of 2 discharged tenants reviewed (Tenants C1 and C2). Findings follow:	A 290			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 290	<p>Continued From Page 18</p> <p>1. a. Record review on 7-26-22 and 8-1-22 of Tenant C1's file revealed Progress Notes indicated on 9-20-21 an order was received for ketotifen fumarate drops, instill one drop in affected eye, three times per day for three days, due to swelling in both eyes.</p> <p>Continued record review revealed nurse's notes did not reflect an entry related to the completion of Tenant C1's eye drops and if the swelling had resolved.</p> <p>b. Review of Progress Notes revealed on 11-2-21 staff observed Tenant C1 laying on the floor on her right side. Tenant C1 said she had fallen off of the bed. A small excoriated area was noted on Tenant C1's eyebrow. Family was contacted and declined an evaluation in the emergency room (ER). Tenant C1 was assisted back to bed with two people and a mechanical lift. On 11-3-21 a fax was received from the primary care provider (PCP) in response to Tenant C1's fall. The PCP indicated "psych meds are likely cause of falls" and ordered lab work.</p> <p>Review of fax cover sheets revealed the PCP was faxed on 11-3-21 after Tenant C1 had another fall out of bed, experiencing two falls within 24 hours. Tenant C1 was able to ambulate but was weak.</p> <p>Continued record review revealed Nurse's notes were not completed when Tenant C1 had a second fall in 24 hours as noted on the 11-3-21 fax to the PCP.</p> <p>c. Record review revealed the November 2021 medication administration records (MARs) Tenant C1 was hospitalized on 11-3-21 at the time of the 6:00 p.m. medication administration. The</p>	A 290			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 290	<p>Continued From Page 19</p> <p>medication was charted as not given and the reason charted was hospitalization.</p> <p>Continued record review revealed nurse's notes were not completed when Tenant C1 was sent to the hospital and the reason for her being sent to the hospital.</p> <p>2. a. Record review on 7-26-22, 8-1-22 and 8-2-22 of Tenant C2's file revealed Progress Notes indicated on 10-20-21 it was noted Tenant C2 returned at about 2:00 a.m. from the hospital. She had orders for Percocet 5/325 milligram (mg), one tablet every six hours as needed for pain, pulse oximetry checks twice daily, incentive spirometer three times daily for seven days, ambulate two to three times per day and to return for trouble breathing, increased pain, increased confusion or concerns. Tenant C2 was resting in her recliner and had complaints of pain on her left side (where the rib were fractured).</p> <p>Continued record review revealed Tenant C2's October MARs directed to check Tenant C2's oxygen saturation every four hours for rib fractures and to report to the nurse readings under 90%. In October 2021 from 10-24-21 to 10-31-21 there were 7 times Tenant C2's oxygen was less than 90%. The November MARs reflected to check Tenant C2's oxygen saturation every four hours for rib fractures and to report to the nurse readings under 90%. In November 2021 there were 5 times Tenant C2's oxygen was less than 90%.</p> <p>Continued record review revealed Progress Notes regarding low oxygen saturations and follow up for Tenant C2 on 10/24/21 and 11/12/21. Additional progress notes regarding incidents of Tenant C2's oxygen reading below 90% could not be located,</p>	A 290			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 290	Continued From Page 20  b. Continued record review revealed October 2021 MARs reflected the following orders: Percocet 5/325 mg, take one tablet, orally every six hours as needed for pain and hydrocodone/APAP 5/325 mg, take one tablet by mouth every six hours as needed. The October MARs indicated Percocet 5/325 mg was administered 5 times from 10-20-21 to 10-25-21 and all entries were documented as not effective. Hydrocodone/APAP 5/325 mg was administered 5 times from 10-26-21 to 10-31-21 and four times it was documented as not effective. Continued review revealed the November 2021 MARs reflected the order for hydrocodone/APAP 5/325 mg, one tablet by mouth every six hours as needed. Hydrocodone/APAP 5/325 mg was administered 9 times from 11-1-21 to 11-11-21 and it was documented as not effective all 9 times.  Further record review of Progress Notes failed to produce nurse follow up related to the pain medication that was routinely charted as not effective.  c. Record review revealed on 10-29-21 it was noted a fax was sent to Tenant C2's PCP regarding a wound on the right foot. An order was received to apply Mepilex and change every other day. An additional fax was sent to the PCP on 10-29-21 to notify Tenant C2 had a large blister on the bottom of her right foot and tenderness and redness on the one side. An order was received to cover the blister with Mepilex and change every other day and monitor for redness  Continued record review revealed a Progress Note on 11-4-21 documented staff called the nurse on-call to inform her of an open blister on Tenant C2's buttocks. The nurse assessed	A 290			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 290	Continued From Page 21  Tenant C2 and noted an open blister to the right buttock. The area measured 6 centimeters (cm) x 4.5 cm. There was also an area of skin that was dark purple and non-blanchable to the "upper coccyx split." Mepilex border was applied over the area on the right buttocks. On 11-5-21 a late entry noted the PCP was faxed regarding a wound on Tenant C2's right foot and buttocks and the area of purple non-blanchable skin that was on the coccyx area.  Additional record review revealed a fax to the PCP on 11-11-21 noted Tenant C2's wound on the "upper coccyx slit" was getting larger. She also had a popped blister would on the right buttocks. The fax indicated "Concerned about worsening." It indicated Tenant C2 was still able to ambulate with assist of one to the bathroom. Staff applied the Mepilex border to the buttocks wound but were unable to dress the coccyx pressure area. It was requested for her to be seen or a referral to the wound clinic. An order was received to refer her to the wound clinic.  Further record review of Tenant C2's Progress Notes did not include any other documented entries or nurse follow up related to the foot, buttocks and coccyx wounds.  3. When interviewed on 8-2-22 at 3:31 p.m. the Clinical Care Specialist confirmed all nurse's notes were provided for the tenants listed above.	A 290			
A 345	481-67.9(4)b Staffing  67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation	A 345			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 345	Continued From Page 22  shall, at a minimum, include the following:  b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s).  This Requirement is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received nurse delegated training on all tasks within 30 days of employment. This pertained to 7 of 8 staff reviewed (Staff A, B, C, D, E, F and G). Findings follow:  1. Record review on 7-21-22 of Staff A's training documents revealed a hire date of 6-16-22. Nurse delegated training was not completed within 30 days of employment for Staff A.  2. Record review on 7-21-22 of Staff B's training documents revealed a hire date of 6-14-22. Nurse delegated training was not completed within 30 days of employment for Staff B.  3. Record review on 7-21-22 of Staff C's training documents revealed a hire date of 5-26-22. Nurse delegated training was not completed within 30 days of employment for Staff C.  4. Record review on 7-21-22 of Staff D's training documents revealed a hire date of 4-22-22. Nurse delegated training related to medications and treatments was completed on 6-3-22; which was greater than 30 days from the Staff D's hire date. The nurse delegated training did not include training on activities of daily living (ADLs).  5. Record review on 7-21-22 of Staff E's training documents revealed a hire date of 5-23-22. Nurse delegated training was not completed within 30 days for Staff E.	A 345			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 345	Continued From Page 23  6. Record review on 7-21-22 of Staff F's training documents revealed a hire date of 3-2-22. Training documents for ADLs were signed by Staff F; however, were not signed by a nurse. The Iowa Nurse Delegation Flowsheet, including for medication management tasks, was signed by Former Healthcare Coordinator #2; however, the training was not documented as completed until 5-13-22.  7. Record review on 7-21-22 of Staff G's training documents revealed a hire date of 1-18-22. Training documents for ADLs were signed off by Staff G; however, were not signed by a nurse.  8. When interviewed on 8-2-22 at 3:31 p.m. the Clinical Care Specialist confirmed all nurse delegation documents for the staff listed above were provided.	A 345			
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 ensure services plans were developed and updated as needed to reflect the identified needs of the tenants. This pertained 3 of 3 of current tenants reviewed (Tenants #1, #2 and #3) and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow:	A 350			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 350	<p>Continued From Page 24</p> <p>1. Record review on 7-26-22 of Tenant #1's file revealed an incident report dated 7-3-22 indicated staff went into Tenant #1's apartment and observed her on the floor. Tenant #1 was on her back near the door and did not use her walker. Tenant #1 said she hit her head and was "experiencing significant back pain." Tenant #1 was transported to the hospital via ambulance.</p> <p>Further record review revealed an After Visit Summary (hospital document) dated 7-3-22 indicated the reason for the visit was a fall with new back pain and arm pain. The diagnosis listed was a "Closed compression fracture of L4 lumbar vertebrae, initial encounter (HCC)."</p> <p>Continued record review revealed Tenant #1's service plan was not updated related to Tenant #1's fall, ER visit and diagnosis of compression fracture.</p> <p>2. Record review on 7-25-22 and 7-26-22 of Tenant #2's file revealed an incident report on 4-28-22 noted Tenant #2 went into a male tenant's apartment and when staff went into the apartment they observed her with her pants down sitting on the bed. Tenant #2 tried to pull the blanket off of the male tenant while he was asleep and tried to hit, bite and throw a picture at that male tenant. The other tenant woke up and grabbed Tenant #2 by the throat and hit Tenant #2. She also tried to hit and bite staff. The tenants were separated and Tenant #2 was back to her apartment. Tenant #2 then chased staff out of her apartment, locked her door and put a chair in front of the door. Tenant #2 went to sleep and staff was able to get into the apartment. No injuries were noted.</p> <p>An incident report on 5-8-22 noted Tenant #2 was</p>	A 350			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 350	Continued From Page 25  very upset with staff and "chose to bite herself "on the right wrist, which left a bruise.  An incident report on 7-9-22 noted Tenant #2 was in a common area and began to throw pens and garbage. Another tenant walked up to Tenant #2 to talk with her. Tenant #2 grabbed the other tenant's shirt and hit her on the right arm. Staff attempted to redirect Tenant #2 and Tenant #2 was "threatening staff that she was going to slit her throat." A nurse was called and Tenant #2 was sent out to the hospital.  An incident report on 7-13-22 it was noted Tenant #2 became agitated and threw food at staff. Staff attempted to redirect, Tenant #2 hit with a closed fist and scratched staff.  The service plan dated 7-14-22 reflected Tenant #2 had become physically aggressive with staff at times. It was noted Tenant #2 liked to throw objects when she was upset. The service plan was not updated when Tenant #2's behaviors occurred and the current service plan did not reflect at times Tenant #2 had behaviors towards other tenants.  3. Record review on 8-2-22 of Tenant #3's file revealed Progress Notes documented on 7-15-22 a fax was sent to the PCP related to Tenant #3's difficulty "swallowing/cough/vomiting while eating." The PCP was also notified about an area to her heel. An order was received for a video pharyngogram. On 8-1-22 it was noted a voicemail was left for Tenant #3's family regarding the swallow study.  Continued record review revealed a Fax Cover Sheet to the PCP dated 7-11-22 indicated staff reported Tenant #3 was vomiting with meals. It	A 350			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 350	Continued From Page 26  was request for a speech therapy referral or if there were other orders. It was also noted Tenant #3 had a sore to the right heel. She was going to be seen by a podiatrist on 7-15-22 and it was covered with a triple antibiotic ointment and bandage until then. The sore "is pinpoint center with half in circle surrounding." The PCP responded with several questions including if she had trouble swallowing, clarified if she was coughing or vomiting and asked how long the sore had been there. It was communicated back to the PCP, that Tenant #3 had difficulty swallowing, coughed and vomited. She was not sure how long the sore had been there. A video pharyngogram was ordered.  Further record review revealed Tenant #3's most recent service plan was dated 1-11-22. The service plan was not updated as needed and did not reflect Tenant #3's difficulty swallowing, coughing and vomiting while eating and the area on Tenant #3's heel.  4. a. Record review on 7-26-22, 8-1-22 and 8-2-22 of Tenant C2's file revealed an incident report dated 10-19-21 at 7:30 p.m. indicated staff went to give Tenant C2 her evening medications and found her on the floor "moaning, crying, complaining of back and chest pain." Staff called the nurse and due to Tenant C2's "extreme pain" the nurse told staff to call the non-emergency ambulance and have Tenant C2 transported to the hospital. An After Visit Summary from the hospital dated 10-19-21 indicated the reason for the ER visit was a fall and diagnoses included fall and closed fracture of multiple ribs (left side). Tenant C2 returned with orders for Percocet 5/325 milligram (mg), one tablet every six hours as needed for pain, pulse oximetry checks twice daily, incentive spirometer three times daily for	A 350			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 350	<p>Continued From Page 27</p> <p>seven days, ambulate two to three times per day and to return for trouble breathing, increased pain, increased confusion or concerns.</p> <p>-Additional record review revealed Progress Notes on 10-24-21 noted staff called a nurse and reported Tenant C2 had been shaky that shift and had recently fractured ribs. It was requested that staff obtain vital signs and call the nurse back. An additional note on 10-24-21 indicated staff called the nurse back and vital signs were as follows: temperature 97.8, blood pressure was 140/82, pulse was 78 and oxygen saturation started at 92% when staff put the oximeter on but it dropped to 88% and 87%. Staff was instructed to give her a pain medication and the nurse would contact the family to see if they wanted anything else done. Tenant C2's family member was contacted regarding her being shaky and low oxygen saturation. Family declined to have her sent out at that time. It was decided to administer the pain medication and monitor Tenant C2's oxygen saturation throughout the night.</p> <p>Continued record review revealed a Long Term Care Facility Acute Visit dated 10-25-21 indicated she had fall on Tuesday night and was transferred to the hospital. Tenant C2 had some rib fractures. She was "now much more reliable on staff and her husband for cares. She was unable to ambulate due to the pain. She needs assistance for feeding from staff and/or her husband." When observed she was in her apartment and appeared to be in "quite a bit of pain." Staff monitored her oxygen saturation every four hours which was lower than normal. Based on the increased cares and falls increased level of care was discussed with Tenant C2's family and the nurse. A Provider Order Sheet dated 10-25-21 indicated orders for lidocaine 4%, on for 12 hours and off for 12 hours and Lortab 5/325 mg, take orally, every hours as</p>	A 350			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 350	Continued From Page 28  needed for rib fractures.  b. Additional record review revealed Progress Notes documented on 10-29-21 a fax was sent to Tenant C2's PCP regarding a wound on the right foot. An order was received to apply Mepilex and change every other day. On 11-4-21 it was noted staff called the nurse on-call to inform her of an open blister on Tenant C2's buttocks. The nurse assessed Tenant C2 and noted an open blister to the right buttock. The area measured 6 centimeters (cm) x 4.5 cm. There was also an area of skin that was dark purple and non-blanchable to the "upper coccyx split." Mepilex border was applied over the area on the right buttocks.  When interviewed on 7-21-22 at 5:02 p.m. Staff I said Tenant C2 refused to be repositioned and staff attempted. She said it got to the point that staff could not do anything with her and she would get aggressive. Staff tried to "flip her" and used a pillow (regarding repositioning her). Tenant C2 needed two people for transfers. She sat in her recliner in her apartment and staff a tried to put a pillow on each side and Tenant C2 refused. Tenant C2 slept in the recliner too. Staff I did not identify any current or discharged tenants with a pressure wound.  When interviewed on 7-25-22 at 12:05 p.m. Staff J said Tenant C2 had a pressure sore on her buttocks and it was first treated with a cream and then a pad was put on it. She said Tenant C2 had fractured her ribs, could not stand well and staff were holding her up. After the rib fracture she was mostly a two person assist. Staff did one hour checks to reposition her and she was in the chair in her apartment. Tenant C2 was agreeable to be repositioned sometimes and at other times	A 350			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 350	<p>Continued From Page 29</p> <p>she had taken the pillow out. She was not able to get out on her own at that point. She received tray meals in the apartment and she could get aggressive. After the rib fracture staff did their best regarding toileting and she was changed in her chair. She was combative towards staff. Staff provided sponge baths after her rib fracture.</p> <p>When interviewed on 7-25-22 at 1:00 p.m. Staff K said Tenant C2 had to be repositioned and she was resting in her chair. Staff would sit in her apartment and feed her and she received a sponge bath. For toileting Tenant C2 took two people to assist. Staff K did not identify any current or discharge tenants with a pressure wound.</p> <p>c. Review of Tenant C2's unsigned service plan, dated 7-16-21, the service plan reflected Tenant C2 needed reminders/cues for toileting, staff checked her protective undergarment and changed it if soiled. If the bandage on her buttocks was peeled staff was to replace it with a silicone bandage. Tenant C2 had a daily wound dressing on the right buttock with Mepilex border. Tenant C2 was an assist of one person. The service plan was not updated when Tenant C2 returned from the hospital after multiple rib fractures and with new orders, required increased cares needs and supervision, changes with ambulation and transfers and discussion regarding a needing a higher level of care. The service plan also did not reflect Tenant C2's pain and interventions and to monitor her breathing and oxygen saturation. The service plan was not updated timely to reflect new wounds to her foot and buttocks which were staged at a II (foot) and III (sacral area). The service plan was also not updated as needed to reflect the worsening of the coccyx wound. There was a 25 pound weight loss from time of the rib fractures until she returned to</p>	A 350			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 350	Continued From Page 30  the hospital on 11-12-21 and the service plan did not reflect weight loss or increased assistance needed with eating.  5. When interviewed on 8-2-22 at 3:31 p.m. the Clinical Care Specialist confirmed all service plans were provided for the tenants listed above.	A 350			
A 370	481-69.26(3)a Service Plans  69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually.  a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.  This Requirement is not met as evidenced by: Based on interview and record review the Program failed to obtain signatures by all parties when a service plan was updated with significant change. This pertained to 3 of 3 current tenants reviewed (Tenants #1, #2 and #3) and 2 of 2 discharged tenants reviewed (Tenants C1 and Tenant C2). Findings follow:  1. Record review on 7-26-22 of Tenant #1's file revealed a Comprehensive Assessment was dated 3-12-22 indicated it was a change of condition due to recurrent falls and to bring to the service plan up to date. The service plan was dated 3-12-22; however, lacked the signature of the nurse who completed the update and the signature of Tenant #1 or Tenant #1's legal representative.	A 370			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 370	Continued From Page 31  2. A Comprehensive Assessment dated 5-1-22 and indicated it was a change of condition to due to multiple falls. The service plan was dated 5-1-22 and was signed by a nurse; however, lacked the signature of Tenant #1 or Tenant #1's legal representative.  3. A Comprehensive Assessment was dated 5-17-22 and it indicated it was change of condition due to a discharge from therapy. The service plan was dated 5-17-22 and was signed by a nurse; however, lacked the signature of Tenant #1 or Tenant #1's legal representative.  4. A Comprehensive Assessment was dated 7-11-22 and it indicated it a change of condition for the start of therapy and falls. The service plan was dated 7-11-22 and was signed by a nurse; however, lacked the signature of Tenant #1 or Tenant #1's legal representative.  5. Record review on 7-25-22 and 7-26-22 of Tenant #2's file revealed a Comprehensive Assessment was dated 7-14-22 indicated it was a change of condition completed for aggression. The service plan was dated 7-14-22 and was signed by a nurse; however, lacked the signature of Tenant #2 or Tenant #2's legal representative.  6. Record review on 8-2-22 of Tenant #3's file revealed a Comprehensive Assessment was dated 1-11-22 and it indicated it was a change of condition completed for discharge from therapy services. A service plan was dated 1-11-22; however, lacked the signature of a nurse who completed the update and the signature of Tenant #3 or Tenant #3's legal representative.	A 370			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 370	Continued From Page 32  7. Record review on 7-26-22 and 8-1-22 of Tenant C1's file revealed a Comprehensive Assessment was dated 8-25-21 indicated it was a change of condition assessment related to the discontinuation of therapy. The service plan was dated 8-25-21; however, lacked the signature of the nurse who completed the update and the signature of Tenant C1 or Tenant C1's legal representative.  8. Record review on 7-26-22, 8-1-22 and 8-2-22 of Tenant C2's file revealed a Comprehensive Assessment dated 7-16-21 indicated it was a change of condition for a fractured rib. A service plan was dated 7-16-21; however, lacked the signature of a nurse and the signature of Tenant C2 or Tenant C2's legal representative.  9. A Comprehensive Assessment had an effective date of 11-4-21 but was not locked (electronic assessment) and signed until 11-11-21. It indicated it was a change of condition for a wound. A service plan was dated 11-4-21; however, lacked the signature of a nurse who completed the update and the signature of Tenant C2 or Tenant C2's legal representative.  10. When interviewed on 8-2-22 at 3:31 p.m. the Clinical Care Specialist confirmed all service plans for the tenants listed above were provided.	A 370			
A 420	481-69.27(1)a Nurse Review  69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse	A 420			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 420	Continued From Page 33  review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse:  a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders  This Requirement is not met as evidenced by: Interview and record review revealed the Program failed to ensure physician orders were current and that medications were administered consistent with the orders by notation of the orders with time, date and signature. This pertained to 2 of 2 discharged tenants reviewed (Tenants C1 and C2). Findings follow:  1. Record review on 7-26-22 and 8-1-22 of Tenant C1's file revealed orders and communication with the primary care provider (PCP) indicated the following:  -An After Visit Summary document dated 8-20-21 was not noted with signature, date or time.  -An order dated 9-17-21 for Zaditor eye drops, instill 1 drop, three times per day for three days was received. The order was not noted with signature, date or time.  -A Fax Cover Sheet dated 11-3-21 indicated Tenant C1 had another fall out of bed and had two falls in 24 hours. The PCP indicated "psych meds are likely culprit." Orders were received for lab work. The order was noted; however, it was	A 420			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 420	Continued From Page 34  not noted until 11-12-21.  2. Record reivew on 7-26-22, 8-1-22 and 8-2-22 of Tenant C2's file revealed orders and communication with the PCP revealed the following:  -A Fax Cover Sheet dated 9-8-21 indicated the PCP was made aware of a fall with Tenant C2. The document was noted; however, it was noted by unlicensed staff and it was not noted until 2-23-22.  -A Long Term Care Facility Acute Visit with the PCP document dated 9-10-21. The visit document was not noted.  -A Fax Cover Sheet dated 9-22-21 indicated the PCP was made aware Tenant C2 fell and a request for physical therapy (PT) as appropriate. The PCP said PT could be attempted. The order was not noted with signature, date or time.  -A Long Term Care Facility (routine visit) with the PCP document dated 10-18-21. The visit document was noted; however, it was noted by unlicensed staff and it was not noted until 2-25-22.  -A Fax Cover Sheet dated 10-22-21 indicated the PCP was made aware Tenant C2 had a fall and went to the hospital. Tenant C2 had multiple left sided rib fractures. Tenant C2 returned with new orders. The document was noted; however, it was noted by unlicensed staff and it was not noted until 2-23-22.  -A Long Term Care Facility Acute Visit with the PCP document was dated 10-25-21. The visit document was noted; however, it was noted by an unlicensed staff and it was not noted until 2-23-22.	A 420			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 420	Continued From Page 35  -A Provider Order Sheet dated 10-25-21 reflected new orders for lidocaine 4% patch, one for 12 hours and off for 12 hours and Lortab 5/325 milligram, take orally every four hours as needed for rib fractures. The orders were noted; however, were noted by unlicensed staff and were not noted until 2-23-22.  -A Fax Cover Sheet dated 11-18-21 sent to the PCP indicated Tenant C2 would not be returning to the Program and would be moving to a higher level of care. It was noted; however, it was noted by unlicensed staff and it was not noted until 2-25-22.  3. When interviewed on 8-2-22 at 3:31 p.m. the Clinical Care Specialist said she identified the issue a couple of months ago and addressed it with the Former Healthcare Coordinator #2, regarding having unlicensed staff note orders. She said there was no actual timeframe but said it should be noted within 24 hours.	A 420			
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure  69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.  This Requirement is not met as evidenced by: Based on observation, interview and record review the Program failed to have an operating door alarm on all exit doors. This potentially affected all tenants (census of 22). Findings follow:  Observation on 7-21-22 at approximately 9:00 a.m. and on 8-2-22 at 10:30 a.m. and 3:29 p.m. revealed the lower level exit door (northeast door) was not alarmed. The door was opened without	A 635			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IAALP076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARNETT PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 35TH ST DR SE CEDAR RAPIDS, IA 52403</b>		
(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 635	Continued From Page 36  an alarm to alert staff.  Record review revealed the Program had an Assisted Living Program Certificate for a Dedicated Dementia Specific Assisted Living Program.  Continued record review revealed the ALP/ADS/EGH Monitoring Entrance Form indicated the Program was an ALP/D with 22 tenants and 5 tenants had a Global Deterioration Scale of 4 or greater.  When interviewed on 8-2-22 at 3:31 p.m. the Clinical Care Specialist said there had been no elopements since she had been involved with the building (mid-January). On the lower level of the building there was a dining room and the beauty shop. She confirmed there was no alarm on the lower level door.	A 635			

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.