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
	S0195	A. BUILDING: _____ B. WING _____	C 02/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE CEDARS MEMORY CARE	6325 ROCKWELL DRIVE NE CEDAR RAPIDS, IA 52402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 13 TOTAL Census of Assisted Living Program for People with Dementia: 13 An onsite infection control visit was completed and no regulatory insufficiencies were identified. A comment was made to the program regarding at times observing staff not wearing their masks. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program and the investigation of Complaint #102204-C and the investigation of Incident #102301-I:	A 000	POC attached OK 5-19-22	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow its policy and procedures related to the completion of incident reports and responding to door alarms. This pertained to 1 of 5 tenants reviewed (Tenant #1). Findings follow: 1. Record review on 2-14-22 to 2-16-22 of Tenant #1's file revealed Tenant #1 had a	A 150		

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diagnosis included late onset Alzheimer's disease with behavioral disturbance. Tenant #1 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Observation notes indicated the following:

-On 9-13-21 it was noted on 9-10-21 at approximately 7:10 p.m. staff was outside with tenant, taking him for walk and the other staff was in the sunroom fixing the television. The memory care door alarm went off and when staff left to look at the door and discovered Tenant #1 was missing. Staff left the memory care door and heard Tenant #1 talking in the kitchen with dietary staff. After a brief discussion, staff was able to redirect Tenant #1 back to the memory care unit. When staff asked why she had left, she said she was looking for her sister. Vitals were not taken and Tenant #1's family was not notified as Tenant #1 was redirected back to the memory care unit.

-On 12-20-21 it was noted a nurse followed with on a staff communication and incident report over the weekend. The incident report indicated Tenant #1 was wandering in the hallway outside of the memory care unit and was near the kitchen. Tenant #1 was found by dietary staff, they called direct care staff to come and get Tenant #1. She was taken back to the memory care unit by direct care staff. Tenant #1 did not have any injuries.

-On 1-26-22 it was noted nursing staff was notified on 1-25-22 at approximately 4:30 p.m. that both memory care staff were in a tenant apartment and when they came out to the common area, dietary staff was bringing Tenant #1 back to memory care. Dietary staff reported Tenant #1 was walking in the hall next to the dining room. Staff reported they did not hear the

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door alarm go off and were not sure how Tenant #1 left the unit. Tenant #1 was easily redirected and was looking for someone.

Continued record review revealed an incident report was not completed related to the incident on 9-10-21.

2. Record review of an Incident Report dated 12-18-21 at 9:00 a.m. indicated Tenant #1 walked out of memory care and dietary staff found her and contacted direct care staff. Tenant #1 was returned to memory care. There were not vital signs documented on the incident report. A nurse was notified at 9:30 a.m. and said to notify nursing there were any changes in her behavior. The incident report was completed by Staff G and dated 12-18-21. Tenant #1's family was notified on 12-20-21. The primary care provider (PCP) was notified on 12-20-21. The nurse follow up section on the report indicated Tenant #1 was doing well and was at her baseline, regarding mental status. When the incident was investigated care staff reported they were helping another tenant.

Continued record review revealed door alarm records indicated a door alarm went off at the memory care door at 9:13 a.m. Another door alarm went off at the memory care door at 9:14 a.m. The incident report time was documented as 9:00 a.m.

When interviewed on 2-21-22 at 10:21 a.m. Staff G said another staff asked for help Tenant #5's apartment. She said dietary staff notified Staff D (working on the general population side) that Tenant #1 was out of the unit and Staff D brought her back to memory care unit. Staff D said she would stay there until staff were done assisting

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Tenant #5. Staff saw Tenant #1, 10 to 15 minutes before she was brought back. The door alarm and pagers did not go off. Staff D was not carrying a pager.

Further record review revealed there were no witness statements for staff involved and there were investigation notes provided related to the elopement. Vitals were not documented on the incident report and names of other staff involved were not included on the incident report. The incident report lacked detail regarding the door alarms and pagers and staff response.

3. Record review of an Incident Report dated 1-25-22 at 4:00 p.m. indicated both memory care staff were in a tenant apartment and when staff were done in that apartment, dietary staff were brining Tenant #1 back into the memory care. Dietary staff said she was walking in the hall next to the dining room. Tenant #1 was easily redirected back to memory care and was looking for someone. There were no vital signs documented. Nurses were notified at 4:00 p.m. and staff were instructed to notify them if there were any further exit seeking behaviors. Tenant #1's family was notified on 1-26-22. The PCP was notified on 1-26-22.

When interviewed on 2-15-22 at 3:29 p.m. Staff F said Tenant #4 had fallen. Both staff were in his apartment and Tenant #1 was in the common area. Staff F was still in Tenant #4's apartment and Staff H went back out and dietary staff was walking Tenant #1 back into the unit. Dietary staff said Tenant #1 was in the hallway by the dining room. Both staff were supposed to have a pager, she did not have her pager. Staff did not hear the door alarm or pager. Tenant #1 had no injuries. She said there were a few other times Tenant #1

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had gotten out of the door. This was the only time they did not 'not hear door alarm or pager. She said Tenant #4's door was open and they did not hear the door alarm. She estimated it was less than five minutes from when Tenant #1 was last seen and she was back in the unit. She said nursing staff looked back at the door alarms and there was not an exact match of time. She said Tenant #1 needed one to one assistance and an incident like that only happened if there were not staff there.

When interviewed on 2-16-22 at 3:46 p.m. Staff H said she was working second shift in memory care with Staff F. She was in another tenant's apartment and then to Tenant #4's apartment to help Staff F after a fall. It was before supper, approximately 4:15 p.m. to 4:30 p.m. Tenant #4's apartment door was partially closed. Dietary staff brought Tenant #1 back to the memory care unit and said she was walking in the hallway. Tenant #1 had no injuries. She said she last saw Tenant #1 right before she went to help the first tenant and then was called to Tenant #4's apartment to help Staff F. At that time Tenant #1 was in her recliner and the door was shut to the apartment. She estimated it was five minutes at the most from when she was last seen until dietary staff brought her back. She said she did not hear the door alarm or hear a pager when Tenant #1 left the unit. She said the medication aide handled the incident reports and she did not complete a witness statement. She said memory care was understaffed related to Tenant #1. A third person was needed, if both staff were in the apartments, staff could not keep an eye on her. She said it was very difficult to stay with her and handle the other tenants. She said Tenant #1 needed a one to one assistance.

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A 150	Continued From page 5 When interviewed on 2-17-22 at 4:13 p.m. Nurse #2 said she remembered Staff F reporting that dietary staff brought Tenant #1 back to memory care. There were no injuries to Tenant #1. When interviewed on 2-21-22 at 12:38 p.m. the Executive Director said she found the incident report for the 1-25-22 incident when gathering things for the visit. She talked to nursing staff who staff was busy and dietary staff brought her back. She was not sure how long she was gone but did not have any injuries. The door alarms functioned and it would have reflected on the pager. Continued record review revealed door alarm records indicated a door alarm went off at the memory care door at 4:06 p.m. Another door alarm at the memory care door was indicated at 4:08 p.m. Further record review revealed there were no witness statements for staff involved and there were investigation notes provided related to the elopement. Vitals were not documented on the incident report and names of other staff involved were not included on the incident report. The incident report lacked detail regarding the door alarms and pagers and staff response. 4. Further record review revealed the Welcome to the Keystone Cedars Memory Care training document indicated staff would immediately respond to every alarm. If staff did not identify anyone near the door, to complete a head count of all tenants in memory care. If all tenants were not accounted for then staff was to implement the missing tenant or elopement policy. The Emergency Call System and Pagers document indicated staff would immediately respond to the	A 150		

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apartment number or the location as indicated on the pager. Staff would designate another staff if they were unable to immediately respond to the page.

5. Record review of a written statement dated 2-18-22 by Staff E indicated on the morning of 2-12-22, Staff E witnessed Staff G "verbally abuse" Tenant #1. She also witnessed her hold the bathroom door closed so Tenant #1 could not get out. Later in the day Staff G put an ice cube down Tenant #1's back "thinking it was funny." The next morning Staff G came into the memory care unit and was angry because "I told on her" and she was removed the memory care unit. Staff G was banging and slamming things and being disrespectful.

When interviewed on 2-15-22 at 9:16 a.m. and 2-21-22 at 9:34 a.m. Staff E said Staff G was pulled out of memory care on Sunday. Staff G yelled at Tenant #1 and told her to sit down and get away. It happened on first shift on Saturday. It made Tenant #1 more angry and irritable. She it happened approximately four to six times during the shift. She also said she was in Tenant #1's apartment, sometime before 7:00 a.m. and she asked Staff G to come in. Staff G said "God dammit ...we aren't doing this today." She said Staff G tried to be funny and it was not funny. Staff E asked Tenant #1 to go to the bathroom and it took awhile for her to sit down and she kept getting up. Staff E left the bathroom and went to get Tenant #1's clothes. Tenant #1 stood up to get off the toilet and Staff G closed the bathroom door and held it shut. Staff G held the door shut with both hands on the handle. Tenant #1 was yelling. Staff G did not hold the door shut too long and Staff E said she was pretty sure she told her to stop it. Staff E said later that day at

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approximately 1:00 p.m. in the kitchen area of the memory care unit Staff G asked for a piece of ice and put an ice cube down Tenant #1's back when she was standing by the sink. Tenant #1 started hitting and yelling for Staff G to take it out. Staff E messaged Staff I, venting to her and Staff I told her she needed to tell one of the nurses. She called Nurse #2 after work and was told she needed to call the Executive Director. She told the Executive Director about the verbal concern and the bathroom door but forgot about the ice cube. Staff E confirmed in interview her statement dated 2-18-22 was accurate. Staff E said she did not have any conflict with Staff G.

When interviewed on 2-21-22 at 10:21 a.m. Staff G said she worked first shift with Staff E on that weekend in memory care. She said at approximately 7:30 a.m. or 8:00 a.m. she went into Tenant #1's apartment. She said Tenant #1 was in a Tenant #1 mood. Staff E was getting her clothes and Tenant #1 was on the toilet. Staff G said she usually shut everyone's door when they were toileting for privacy. If a tenant needed assistance then she stayed with with them. Staff G shut the door, it was not shut for long. Staff G stood at the hinge of the door and had her hand on the handle but was not holding it. Tenant #1 was able to open the door. Staff G heard her stand up. There was no assistance provided after toileting as Tenant #1 did not go. Staff G denied any inappropriate verbal comments towards Tenant #1. She said after breakfast, approximately 10:00 a.m. to 10:30 a.m. she noticed a couple of black lines on the back of Tenant #1's neck. She got a towel wet with water from the faucet that was extremely hot and she did not want to hurt her. She took an ice cube and made a line with the ice cube on her skin and then wiped it with the towel. She said Tenant #1

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was mad something cold was put on her. She turned around and hit Staff G. There was not an incident report completed related to the incident. Staff G said there was not conflict between Staff E and Staff G. She said Staff E wanted to change weekends. She said Tenant #1 liked to poke at staff.

Continued record review revealed there was not an incident report completed related to Staff E's allegations from 2-12-22 or a written statement completed by Staff G in response to the allegations. Staff E's written statement was dated 2-18-22 and the incidents allegedly occurred on 2-12-22. Staff G said Tenant #1 hit her after she made a line with an ice cube on her skin. An incident report was not completed related to that incident.

6. When interviewed on 2-21-22 at 12:38 p.m. the Executive Director all incident reports and witness statements were provided for the tenant listed above.

7. In summary, record review revealed there were no witness statements for staff involved and there were investigation notes provided related to the elopement. Vitals were not documented on the incident report and names of other staff involved were not included on the incident report. The incident report lacked detail regarding the door alarms and pagers and staff response. In both incidents staff said they did not hear door alarms or pagers. Not all staff were carrying pagers at the time of the elopements. Door alarm records showed the memory care doors alarmed within 15 minutes of the time of the elopements as indicated on incident reports. None of the staff witnessed Tenant #1 leaving the unit and video evidence could not be provided related to the

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A 150	Continued From page 9 dates indicated above. The memory door alarms either failed to alarm per policy and procedure or staff failed to respond to the door alarms per policy and procedure. Staff failed to complete incident reports as required.	A 150		
A 155	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure a tenant was treated with consideration, respect and full recognition of personal dignity and autonomy. This pertained to 1 of 5 tenants reviewed (Tenant #1). Findings follow: 1. Record review of a written statement dated 2-18-22 by Staff E indicated on the morning of 2-12-22, Staff E witnessed Staff G "verbally abuse" Tenant #1. She also witnessed her hold the bathroom door closed so Tenant #1 could not get out. Later in the day Staff G put an ice cube down Tenant #1's back "thinking it was funny." The next morning Staff G came into the memory care unit and was angry because "I told on her" and she was removed the memory care unit. Staff G was banging and slamming things and being disrespectful.	A 155		

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A 155	Continued From page 10 2. When interviewed on 2-15-22 at 9:16 a.m. and 2-21-22 at 9:34 a.m. Staff E said Staff G was pulled out of memory care on Sunday. Staff G yelled at Tenant #1 and told her to sit down and get away. It happened on first shift on Saturday. It made Tenant #1 more angry and irritable. She reported it happened approximately four to six times during the shift. She said Staff E was in Tenant #1's apartment, sometime before 7:00 a.m. and asked Staff G to come in. Staff G said "God dammit ...we aren't doing this today." She stated Staff G tried to be funny and it was not funny. Staff E asked Tenant #1 to go to the bathroom and it took awhile for her to sit down and she kept getting up. Staff E left the bathroom and went to get Tenant #1's clothes. Tenant #1 stood up to get off the toilet and Staff G closed the bathroom door and held it shut. Staff G held the door shut with both hands on the handle. Tenant #1 was yelling. Staff G did not hold the door shut too long and Staff E was pretty sure she told her to stop it. Staff E said later that day at approximately 1:00 p.m. in the kitchen area of the memory care unit Staff G asked for a piece of ice and put an ice cube down Tenant #1's back when she was standing by the sink. Tenant #1 started hitting and yelling for Staff G to take it out. Staff E messaged Staff I, venting to her and Staff I told her she needed to tell one of the nurses. She called Nurse #2 after work and was told she needed to call the Executive Director. She told the Executive Director about the verbal concern and the bathroom door but forgot about the ice cube. Staff E confirmed in interview her statement dated 2-18-22 was accurate. Staff E reported no conflicts with Staff G. When interviewed on 2-21-22 at 10:21 a.m. Staff G said she worked first shift with Staff E on that weekend in memory care. She reported at	A 155		

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approximately 7:30 a.m. or 8:00 a.m. she entered Tenant #1's apartment and said Tenant #1 was in a Tenant #1 mood. Staff E was getting her clothes and Tenant #1 was on the toilet. Staff G stated she usually shut everyone's door when they were toileting for privacy. If a tenant needed assistance then she stayed with with them. Staff G shut the door, it was not shut for long. Staff G stood at the hinge of the door and had her hand on the handle but was not holding it. Tenant #1 was able to open the door. Staff G heard her stand up and provided no assistance after toileting as Tenant #1 did not go. Staff G denied any inappropriate verbal comments towards Tenant #1. She said after breakfast, approximately 10:00 a.m. to 10:30 a.m. she noticed a couple of black lines on the back of Tenant #1's neck. She got a towel wet with water from the faucet that was extremely hot and she did not want to hurt her. She took an ice cube and made a line with the ice cube on her skin and then wiped it with the towel. She said Tenant #1 was mad something cold was put on her. She turned around and hit Staff G. There was not an incident report completed related to the incident. Staff G said there was not conflict between Staff E and Staff G. She said Staff E wanted to change weekends. She said Tenant #1 liked to poke at staff.

When interviewed on 2-15-22 at 3:29 p.m. Staff F said on Sunday Staff E told her that Staff G leaned up against the bathroom door to Tenant #1's bathroom so she could not get out. Staff F was not witness to the allegation and heard it from Staff E.

When interviewed on 2-21-22 at 9:57 a.m. Staff I said she got a text message from Staff E who reported Staff G yelled at Tenant #1, medications

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were not getting passed, and a catheter bag was not changed. She told Staff E to call the on-call nurse.

When interviewed on 2-21-22 at 10:52 a.m. Nurse #2 (on-call nurse) said on 2-12-22 at 2:30 p.m. Staff E reported Staff G was not toileting tenants, quite a few of her tenants slept in that morning, did not come to lunch and Staff G told Tenant #1 to "shut up." She told Staff E to call the Executive Director. She said there was no conflict before 2-12-22 between Staff E and Staff G.

3. Continued record review on 2-14-22 to 2-16-22 of Tenant #1's file revealed Tenant #1 had a diagnosis included late onset Alzheimer's disease with behavioral disturbance. Tenant #1 was staged at a six on the Global Deterioration Scale GDS, which indicated severe cognitive decline. Tenant #1's current service plan indicated :for toileting assistance, to provide assistance and stay in the bathroom with Tenant #1. Staff was to cue Tenant #1 in the bathroom and assist with perineal care. The service plan reflected Tenant #1's dementia was worsening and she had "bouts of aggression/agitation with both staff and other tenants."

Further record review revealed the Program's investigation indicated the following:

-On 2-12-22 the Executive Director received a call from Staff E who was frustrated. Staff E reported concerns including that Staff G was rude to Tenant #1 and "basically yelled at her to shut up."

-On 2-15-22 the Executive Director was informed of hearsay allegations during the onsite

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investigation. She interviewed Staff G and she denied yelling at Tenant #1. She said Tenant #1 was on the toilet, she shut the door, waited outside to provide privacy. Staff G denied holding the door shut.

-On 2-17-22 the Executive Director interviewed Staff E and she stated when Staff G assisted Tenant #1, she said "God dammit...; we are not going to do this today." Staff E expressed Staff G's presence and her behavior agitated Tenant #1 more. They took Tenant #1 to the bathroom, Staff E left and when she came back Staff G was holding the door shut. Staff E reported around the lunch meal, Staff G asked her for a piece of ice and then Staff G put it down Tenant #1's back. Staff E said Tenant #1 yelled and swung at Staff G. Staff E reported Staff G kept asking her all day if she was mad at her. She also said Staff G came to the the memory care unit on Sunday, slammed doors and was upset.

The investigation document indicated the video was reviewed from first shift in memory care and the Executive Director could not see any evidence of Staff G putting ice down Tenant #1's shirt or her reaction. She called Staff E to clarify she left the apartment and came back and saw Staff G holding the door shut while Tenant #1 was in the bathroom. Staff E said she left the bathroom to get Tenant #1's clothes but did not leave the apartment. When she returned from the closet to the bathroom, Staff G was holding the door shut while Tenant #1 was in the bathroom. It occurred for less than a minute.

-On 2-21-22 the Executive Director spoke with Staff E. She was "adamant" that she did not hold the bathroom door shut and said it was shut for Tenant #1's privacy. She was asked if she put ice

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down Tenant #1's shirt and she denied it. She said she asked Staff E for an ice cube and "swiped it across a smudge of dirt on ... neck quickly and then wiped with warm rag." She said the rag was too warm. When asked why she did not use water that was cooler she said she did not know. When asked why someone would make these allegations she said Staff E was upset with her about Staff G not wanting to trade shifts with her.

4. When observed on 2-21-22 footage from Memory Care #1 camera indicated the following:

-There was a 22 minute difference from real time to video time noted. The below started at 1:30 p.m. video time (1:08 p.m. real time). There was no audio provided with the video footage.

-At approximately 1:30 p.m. video time (1:08 p.m. real time), Staff G is observed at the kitchen area and appeared to be putting away silverware or dishes. Staff E comes into the kitchen area and appeared to be putting away dishes or silverware. Tenant #1 is off camera most of the time but she was observed just outside of the camera view in the kitchen area. Staff E turned and reached into the freezer, turned back toward Staff G, who was next to her. Staff G was then out of the camera view. Staff E was seen leaving the kitchen area and Staff G went to the nurse's station. At approximately 1:33 p.m. (video time) Tenant #1 followed Staff G and she appeared to be pulling on the bottom of the back of her shirt. The video footage did not show Staff G putting ice down Tenant #1's shirt or on her neck.

5. Further record review revealed there was not an incident report completed related to Staff E's allegations from 2-12-22 or a written statement

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A 155	Continued From page 15 completed by Staff G in response to the allegations. Staff G said Tenant #1 hit her after she made a line with an ice cube on her skin. An incident report was not completed related to that incident. In summary, Staff E reported allegations regarding Staff G and the treatment of Tenant #1 to co-workers, the nurse on-call and the Executive Director. Staff E alleged that Staff G was verbal abusive towards Tenant #1, she alleged Staff G shut and held the bathroom door closed while Tenant #1 was in the bathroom and she alleged Staff G put an ice cube down Tenant #1's shirt. Staff G denied the verbal allegation and said she closed Tenant #1's bathroom door for privacy and had her hand on the handle but was not holding it shut. Review of Tenant #1's service plan indicated staff were to stay with her in the bathroom for toileting. Video observation revealed Staff E, Staff G and Tenant #1 in the kitchen area. Staff E reached into the freezer and turned towards Staff G. Shortly after Tenant #1 was seen pulling at the bottom of the back of her shirt. Staff G said she took an ice cube and made a line on her skin to remove black lines on her neck and then wiped it with the towel. Tenant #1 was mad something cold was put on her and she hit Staff G. Staff E and other staff reported there was no conflict between Staff E and Staff G prior to 2-12-22. Staff G said there was no conflict but Staff E wanted to change weekends. Tenant #1 was not treated with personal dignity, respect and autonomy.	A 155		
A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified	A 361		

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and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:

f. Services shall be provided to tenants in accordance with the training provided.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review the Program failed to have staff provide services in accordance with training provided. This pertained to 1 of 1 tenant observed that had liquid medication administered (Tenant #3). Findings follow:

1. When observed on 2-15-22 at 11:40 a.m. Staff D administered medications including to Tenant #3. Staff D prepared Tenant #3's liquid medication, fluoxetine (Prozac) 10 milliliters (ml)/40 milligrams (mg). She poured the liquid medication into a medication cup and then mixed it with Tenant #3's milk. It was provided to Tenant #3 at the dining room table during lunch. Staff D signed off the medication after it was provided to Tenant #3.

When interviewed at the time of the medication pass, Staff D said Tenant #3 liked milk and was agreeable to drink the milk. She said there were no issues with other tenants picking up her glass and drinking it.

Continued observation indicated at 12:04 p.m. Tenant #3's milk (with medication) remained on the table. Tenant #3 was still seated at the table.

2. Record review of Tenant #3's file revealed a diagnosis of Alzheimer's disease. Tenant #3 was staged at a four on the Global Deterioration

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A 361	Continued From page 17 Scale, which indicated moderate cognitive decline. The service plan reflected staff administered Tenant #3's medications. Continued record review of Tenant #3's February 2022 medication administration record (MARs) reflected an order for fluoxetine (Prozac), give 10 ml (40 mg), liquid medication, mixed with milk daily at lunch (at 12:00 p.m.). The Med Pass History reflected Staff D's initials for the administration of the medication at 11:43 a.m. 3. Further record review revealed Staff D had a Med Aide Delegation Checklist completed dated 12-7-21, which indicated training was completed for liquid medication administration. 4. Continued record review revealed the training for liquid medication administration indicated to administer the medication and to remain with the tenant until it was consumed. To document the medication as administered by selecting the "pass med" button. 5. When interviewed 2-21-22 at 12:38 p.m. the Executive Director said she would expected staff to observe before signing off the medication.	A 361		
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	A 145		

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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 significant change.

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 occurred for 1 of 2 tenants reviewed with wounds (Tenant #3) and 1 of 1 tenant reviewed with a catheter (Tenant #4). Findings follow:

1. Record review on 2-16-22 of Tenant #3's file revealed a diagnosis of Alzheimer's disease. Tenant #3 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline.

When interviewed on 2-15-22 at 10:02 a.m. Staff D said Tenant #3 told her all the time she wished she had a knife and then made a cutting gesture to cutting her wrists. She said it occurred at least two to three times per week.

Continued record review revealed a Staff/Nurse Communication Report form dated 12-30-21 reflected when staff helped Tenant #3 get up and dressed that morning, Tenant #3 said she "really" wanted staff to give her a knife.

A Staff/Nurse Communication Report form dated 1-1-22 reflected staff reported change in Tenant #3's skin integrity. The form indicated a pressure ulcer was noted to the lower left buttock and Mepliex was applied by staff.

Further record review revealed Observation notes

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A 145	Continued From page 19 indicated the following: -On 12-30-21 it was noted staff reported when assisting Tenant #3 with morning cares that she "really" wanted staff to give her a knife. Tenant #3 had a history depression and said things similar to it. Tenant #3 was prescribed Prozac 40 milligram (mg) (liquid) daily with milk at lunch. The primary care provider (PCP) was notified. -On 1-4-22 (nurse review) it was noted a nurse followed up on a staff to nurse communication report related to a sore on Tenant #3's left buttocks. Tenant #2 had a stage 2 pressure sore on her buttocks. The note indicated the "edges are a little red but middle is bruising." Tenant #2 did not know where she got the pressure sore. Tenant #2 spent a lot of time in her bed when she was feeling depressed. The service plan would be updated for the sore. The PCP was faxed for orders. The nurse applied Mepliex to the area. -On 1-4-22 it was noted an order was received to apply Mepliex to the the left buttocks, change every three days, until healed. -On 2-9-22 it was noted a nurse followed up regarding Tenant #3's buttocks. Her buttocks was "red and beefy looking in circular shape as it was previously. This area was was black looking in the middle when RN first originally saw it. It is looking better." Tenant #3 did not have any pain. It was noted nursing staff would continue to monitor. Continued record review revealed a fax to the PCP dated 12-7-21 reflected a 90 day assessment was completed and Tenant #3 had lost 11.8 pounds. It was indicated it could be due to her history of depression and not getting out	A 145		

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bed on some days.

A fax to the PCP dated 12-30-21 reflected Tenant #3 said that she wanted a knife when staff was assisting her with cares. It was noted she had a history of saying "these things but does not have a plan."

A fax to the PCP dated 1-4-22 reflected Tenant #3 had a "golf size stage 2 wound/pressure sore" to the left buttocks. It was most likely from Tenant #3 not moving much and and being in bed some days. An order was received for Mepliex, change every three days until healed.

Further record review revealed cognitive, health and functional evaluations (annual) were most recently completed on 6-15-21. Evaluations were not completed as needed comments regarding wanting a knife and gestures to her wrist, weight loss and a stage 2 pressure ulcer.

2. Record review on 2-16-22 of Tenant #4's file revealed diagnoses included: Alzheimer's disease and prostate cancer. Tenant #4 was staged at a five on the GDS. Tenant #4 was admitted on 1-24-22 and pre-admission evaluations were completed dated 12-31-21.

Observation notes indicated the following:

-On 1-25-22 it was noted a catheter was placed by hospice and the service plan was updated to reflect staff emptied the catheter every four hours as needed. Tenant #4 had a catheter prior to to admission and had urinary retention. Tenant #4 did not void all afternoon and hospice was alerted and they came on 1-24-22 to place the catheter. The service plan was updated.

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A 145	Continued From page 21 -On 1-25-22 it was noted the service plan was updated to reflect staff was to clean Tenant #4's catheter night bag each morning and his day bag each night. Staff assisted with emptying the catheter throughout the day. -On 1-25-22 it was noted a new order was received to irrigate Tenant #4's catheter as needed with sterile water. Continued record review revealed a Physician Order Sheet reflected an order to irrigate the catheter daily as needed with sterile water dated 1-25-22. Further record review revealed evaluations were not completed as needed with significant change, including a new order for catheter care daily as needed and additional services added to the service plan related to catheter care throughout the day. 3. When interviewed on 2-21-22 at 12:38 p.m. the Executive Director confirmed the most current evaluations for the tenants listed above were provided.	A 145		
A 160	481-69.23(1)c(1) Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or	A 160		

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A 160	Continued From page 22 aggression This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to discharge a tenant that exceeded the level of care. This pertained to 1 of 5 tenants reviewed (Tenant #1). Findings follow: 1. When observed at the lunch meal on 2-15-22 staff provided frequent redirection to Tenant #1 throughout the meal. Staff redirected Tenant #1 to her seat, to her plate of food and away from other tenants' tables. 2. Record review on 2-14-22 to 2-16-22 of Tenant #1's file revealed Tenant #1 had a diagnosis included late onset Alzheimer's disease with behavioral disturbance. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Incident Reports indicated the following: -On 8-1-21 it was noted staff was charting and Tenant #1 "darted out" the door. Staff responded to the door alarm and redirected Tenant #1 back to the unit. -On 8-14-21 it was noted Tenant #1 entered Tenant #2's apartment and was redirected out. Tenant #1 came back into Tenant #2's apartment and started yelling at staff that they had to go with her. Staff tried to redirect Tenant #1 but Tenant #2 started yelling at Tenant #1 to get out of his apartment. Tenant #2 continued to yell and Tenant #1 told staff to kick him in the face or she would. Tenant #2 started to chase Tenant #1 out of his apartment and tried to push her out.	A 160		

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Tenant #1 started to punch Tenant #2. Staff stopped Tenant #1 was swing anymore as staff stepped between them. Tenant #1 elbowed staff when staff tried to take her blood pressure. Tenant #1 remained agitated and cried.

-On 8-15-21 it was noted Tenant #1 was participating in an activity and staff started charting. Tenant #1 went out the front memory care door and staff responded to the alarm. Tenant #1 was redirected back into memory care.

-On 8-25-21 it was noted staff was assisting Tenant #2 and Tenant #1 came over to see if she could help and Tenant #2 started yelling for Tenant #1 to go away. Tenant #1 slapped Tenant #2 on the forearm.

-On 8-29-21 it was noted Tenant #1 went out the front memory care door while staff were busy. Tenant #1 did not want to come back to memory care initially and said she saw someone who told her to come out and follow her. Staff immediately responded to the alarm and redirected Tenant #1 back to the unit.

-On 9-14-21 it was noted both staff were busy with other tenants and Tenant #1 left her apartment and walked out the door to find someone. Staff on the general population side noticed she was out of the memory care unit and called for staff assistance. Staff went to get Tenant #1 and got her ice cream and a cookie.

-On 9-18-21 it was staff heard Tenant #2 scream from another tenant's apartment. She found Tenant #1 in Tenant #2's apartment. Tenant #1 was in the bathroom and Tenant #2 had a "very strong grip" Tenant #1's right forearm as he tried to get her out of his apartment. The tenants were

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separated.

-On 9-29-21 it was noted Tenant #1 followed the housekeeping staff and went outside the memory care door.

-On 12-10-21 it was noted Tenant #1 walked around the memory care dining room and went up to Tenant #5's table. Tenant #5 started to yell and he held her forearm and Tenant #1 grabbed his forearm. Staff intervened.

-On 12-18-21 at 9:00 a.m. indicated Tenant #1 walked out of memory care and dietary staff found her and contacted direct care staff. Tenant #1 was returned to memory care. When the incident was investigated care staff reported they were helping another tenant.

-On 1-14-22 it was noted Tenant #5 grabbed Tenant #1 by her left arm and pulled it "all the way behind her back."

-On 1-16-22 it was noted Tenant #1 went to sit on a box and sat down before staff could stop her.

-On 1-25-22 at 4:00 p.m. indicated both memory care staff were in a tenant apartment and when staff were done in that apartment, dietary staff were brining Tenant #1 back into the memory care. Dietary staff said she was walking in the hall next to the dining room. Tenant #1 was easily redirected back to memory care and was looking for someone.

-On 1-19-22 it was noted Tenant #1 was wandering after her meal and did not accept direction from staff to sit down or to go to her apartment. Staff had to keep redirecting Tenant #1 instead of serving the meal. Another tenant

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KEYSTONE CEDARS MEMORY CARE	6325 ROCKWELL DRIVE NE CEDAR RAPIDS, IA 52402

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got upset and started yelling and yelled at Tenant #1 to sit down. Tenant #1 approached the tenant and Tenant #5's table and Tenant #5 began yelling at Tenant #1 as well. Tenant #1 yelled back at Tenant #5 and the two began fighting about her sitting down. Tenant #1 called Tenant #5 a "derogatory term" and Tenant #5 pushed Tenant #1 away. Staff stood between the two tenants. Tenant #1 went back to her apartment with staff and continued to yell at him. Tenant #5 was redirected to sit down at the dining room table.

-On 1-28-22 it was noted Tenant #1 was talking to other tenants when she got upset and grabbed another tenant's arm and "finally" let go of the tenant's arm and then hit another tenant in the head.

-On 1-30-22 it was noted both staff were in an apartment when staff heard the exit door alarm sound. Staff out and found Tenant #1 outside of the memory care unit, next to the exit door.

3. Continued record review revealed the Observation notes indicated the following:

-On 9-13-21 it was noted on 9-10-21 at approximately 7:10 p.m. staff was outside with tenant, taking him for walk and the other staff was in the sunroom fixing the television. The memory care door alarm went off and when staff left to look at the door and discovered Tenant #1 was missing. Staff left the memory care door and heard Tenant #1 talking in the kitchen with dietary staff. After a brief discussion, staff was able to redirect Tenant #1 back to the memory care unit. When staff asked why she had left, she said she was looking for her sister.

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On 1-3-22 it was noted a staff communication report dated 1-2-22 indicated staff reported Tenant #1 hit her three times and attempted to slap her. Staff noted Tenant #1 was more aggressive when she was tired.

-On 1-27-22 it was noted staff reported Tenant #1's aggression was not within her baseline. When staff were busy, "instead of attempting to elope" she tried to go into other tenant apartments and it started an argument. To redirect her out the apartment might take a couple of minutes. It was noted Tenant #1 needed redirection "nearly constantly." When staff attempted to redirect her often she grabbed staffs' arms or wrist and squeezed until staff convinced her to let go. Tenant #1's medication was adjusted that morning to attempt to help with behaviors. Staff would keep Tenant #1 "occupied when able."

-On 1-31-22 it was noted on 1-30-22 Tenant #1 at a meal time got up from the table and tired to walk to another table while other tenants were still eating. Staff attempted to redirect Tenant #1 back to the table, Tenant #1 squeezed staffs' hand and arm and would not let go. When Tenant #1 let go, she hit staff's arm multiple times and then tried to "smash" her sandwich into her face. Tenant #1 picked up her burger and threw it across the room near another tenant. An hour later when both staff were busy with different tenants, Tenant #1 left the memory care unit, the door alarm went off, staff answered the alarm and brought Tenant #1 back.

-On 2-2-22 it was noted on 2-1-22 staff reported when staff were serving Tenant #1 stood up and walked around. Staff attempted to redirect her and she shoved food in the staff's face and hit her

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with a fork.

-On 2-7-22 it was noted Tenant #1 had two falls over the weekend. One fall occurred on 2-5-22 and Tenant #1 was observed on the floor. On 2-6-22 it was noted staff heard her yelling for help. When staff responded they found her on the floor. Tenant #1 complained of back pain. Staff monitored vitals due to low blood pressure.

-On 2-9-22 it was noted Tenant #1 had four falls since the last significant change. Tenant #1 fell on 1-16-22, 2-5-22, 2-6-22 and 2-9-22. On 2-9-22 Tenant #1 was found on the floor at the end of her bed. Tenant #1's head was against the wall. It was noted her pupils did not dilate. This was reported to family and the PCP. Trazodone was decreased to once daily. The service plan was updated to reflect hourly checks due to frequent falls and the medication dosage adjustment.

4. When interviewed on 2-15-22 at 9:16 a.m. Staff E said Tenant #1 hit or punched staff and there were no injuries to staff. She said it occurred everyday with cares.

When interviewed on 2-15-22 at 10:02 a.m. Staff D said staff were hit by Tenant #1 and there were no injuries to staff. She said it was almost everyday.

When interviewed on 2-15-22 at 3:29 p.m. Staff F said Tenant #1 needed one to one assistance and an incident (on 1-25-22) only happened if there were not staff there.

When interviewed on 2-16-22 at 3:46 p.m. Staff H said memory care was understaffed related to Tenant #1. A third person was needed, if both

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staff were in the apartments, staff could not keep an eye on her. She said it was very difficult to stay with her and handle the other tenants. She said Tenant #1 needed one to one assistance. She said Tenant #1 went to other tenant's apartments.

When interviewed on 2-15-22 at approximately 4:35 p.m. Nurse #2 said staff reported Tenant #1 took a lot of redirection when the focus was not on her.

When interviewed on 2-21-22 at 12:38 p.m. the Executive Director said Tenant #1's family was beginning to search for other placement. An official 30 day notice was not given and family was agreeable to alternate placement. She said she would contact family once per week regarding the transfer and if steps were not being taken, then a formal 30 day notice would be given. She said the meeting was held on Friday (2-18-22) with Tenant #1's family.

Further record review review revealed the ALP Monitoring Entrance Form indicated there were two staff on first and second shifts and one staff on third in the memory care unit.

5. In summary, Tenant #1 had nine incidents when she left the memory care unit, including three incidents when it was not indicated that staff heard or responded to the door alarms (elopements). Tenant #1 had noted incidents of aggressive behavior with other tenants and other tenants were also aggressive with her at times. Tenant #1 also had documented incidents of aggressive behavior towards staff. Staff interviews indicated Tenant #1 needed a one to one assist. Tenant #1 exceeded the level of care to remain at the Program related to chronically

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A 160	Continued From page 29 eloping and aggressive behavior.	A 160		
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 observation, interview and record review the Program failed to develop service plans based on the evaluations, failed to update service plans as needed and failed to have service plans reflect the identified needs of the tenants. This pertained to 5 of 5 tenants reviewed (Tenants #1, #2, #3, #4 and #5). Findings follow: 1. Record review on 2-14-22 to 2-16-22 of Tenant #1's file revealed Tenant #1 had a diagnosis included late onset Alzheimer's disease with behavioral disturbance. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. When interviewed on 2-15-22 at 9:16 a.m. Staff E said Tenant #1 hit or punched staff and there were no injuries to staff. She said it occurred everyday with cares. When interviewed on 2-15-22 at 10:02 a.m. Staff D said staff were hit by Tenant #1 and there were no injuries to staff. She said it was almost	A 350		

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everyday.

Continued record review revealed Observation notes indicated the following:

-On 1-3-22 it was noted a staff communication report dated 1-2-22 indicated staff reported Tenant #1 hit her three times and attempted to slap her. Staff noted Tenant #1 was more aggressive when she was tired.

-On 1-17-22 it was noted on 1-16-22 Tenant #1 went to sit on a box (she thought it was a chair) and sat down before staff could stop her. Staff assisted her to a chair.

-On 1-20-22 it was noted on 1-19-22 Tenant #1 got up and was wandering after the evening meal. She did not accept redirection from staff and would not sit down. Another tenant was frustrated with her and started yelling at her to sit down. Tenant #1 approached the table and when she got closer to the table, Tenant #5 also yelled at her. Tenant #1 called Tenant #5 a "derogatory term" and he pushed her away. On 1-14-22, Tenant #1 walked around and touched food and she and Tenant #5 got into an argument. The other tenant grabbed her arm and put it behind her back.

-On 1-27-22 it was noted staff reported Tenant #1's aggression was not within her baseline. When staff were busy, she tried to go into other tenant apartments and it started an argument. To redirect her out the apartment might take a couple of minutes. It was noted Tenant #1 needed redirection "nearly constantly." When staff attempted to redirect her often she grabbed staffs' arms or wrist and squeezed until staff convinced her to let go. Tenant #1's medication

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was adjusted that morning to attempt to help with behaviors. Staff would keep Tenant #1 "occupied when able."

-On 1-28-22 it was noted Tenant #1 was talking with other tenants and an argument started. Tenant #1 grabbed another tenant's hand and would not let go for awhile. After she let go she hit another tenant in the head.

-On 1-31-22 it was noted on 1-30-22 Tenant #1 at a meal time got up from the table and tired to walk to another table while other tenants were still eating. Staff attempted to redirect Tenant #1 back to the table, Tenant #1 squeezed staffs' hand and arm and would not let go. When Tenant #1 let go, she hit staff's arm multiple times and then tried to "smash" her sandwich into her face. Tenant #1 picked up her burger and threw it across the room near another tenant. An hour later when both staff were busy with different tenants, Tenant #1 left the memory care unit, the door alarm went off, staff answered the alarm and brought Tenant #1 back.

-On 2-2-22 it was noted on 2-1-22 staff reported when staff were serving Tenant #1 stood up and walk around. Staff attempted to redirect her and she shoved food in the staff's face and hit her with a fork.

-On 2-7-22 it was noted Tenant #1 had two falls over the weekend. One fall occurred on 2-5-22 and Tenant #1 was observed on the floor. On 2-6-22 it was noted staff heard her yelling for help. When staff responded they found her on the floor. Tenant #1 complained of back pain. Staff monitored vitals due to low blood pressure.

-On 2-9-22 it was noted Tenant #1 had two falls

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since the last significant change. Tenant #1 fell on 1-16-22, 2-5-22, 2-6-22 and 2-9-22. On 2-9-22 Tenant #1 was found on the floor at the end of her bed. Tenant #1's head was against the wall. It was noted her pupils did not dilate. This was reported to family and the PCP. Trazodone was decreased to once daily. The service plan was updated to reflect hourly checks due to frequent falls and the medication dosage adjustment.

Further record review revealed the service plan reflected hourly rounds from 8:00 a.m. to 7:00 p.m. and to complete an activity. The safety check section reflected two hour checks. The service plan did not reflect frequent falls or the Trazodone adjustments. The service plan reflected Tenant #1 had behaviors towards Tenant #5 and a history of aggression towards staff and other tenants. Tenant #1 had more agitation and at times attempted to hit things or staff and leave the memory care unit. The service plan did not reflect the physical behavior towards staff and tenants.

2. Record review on 2-15-22 and 2-16-22 of Tenant #2's file reflected Tenant #6 was on hospice services and was staged at a six on the GDS, which indicated severe cognitive decline.

When observed on 2-15-22 at the lunch meal Staff assisted Tenant #2 with eating, including putting food on the utensil and bring the utensil to Tenant #2's mouth. Tenant #2 used adaptive silverware and a dish for his food.

When interviewed on 2-16-22 at 3:46 p.m. Staff H said regarding eating for Tenant #2, it was dependent on his day. On a good day he would try to eat by himself and on a bad day staff feed

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him a little bit.

Continued record review revealed the service plan reflected staff was to cut up meat and other foods that were tough for Tenant #2. Tenant #2 could get agitated if he was shaking more than his baseline and will not feed himself. Staff to cue and assist with eating as needed. The service plan did not reflect the staff assistance observed and reported at times related to eating.

3. Record review on 2-16-22 of Tenant #3's file revealed a diagnosis of Alzheimer's disease. Tenant #3 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline.

When interviewed on 2-15-22 at 10:02 a.m. Staff D said Tenant #3 told her all the time she wished she had a knife and then made a cutting gesture to cutting her wrists. She said it occurred at least two to three times per week.

Continued record review revealed a Staff/Nurse Communication Report form dated 12-30-21 reflected when staff helped Tenant #3 get up and dressed that morning, Tenant #3 said she "really" wanted staff to give her a knife.

A Staff/Nurse Communication Report form dated 1-1-22 reflected staff reported change in Tenant #3's skin integrity. The form indicated a pressure ulcer was noted to the lower left buttock and Mepliex was applied by staff.

Further record review revealed Observation notes indicated the following:

-On 12-30-21 it was noted staff reported when assisting Tenant #3 with morning cares that she

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"really" wanted staff to give her a knife. Tenant #3 had a history depression and said things similar to it. Tenant #3 was prescribed Prozac 40 milligram (mg) (liquid) daily with milk at lunch. The primary care provider (PCP) was notified.

-On 1-4-22 (nurse review) it was noted a nurse followed up on a staff to nurse communication report related to a sore on Tenant #3's left buttocks. Tenant #2 had a stage 2 pressure sore on her buttocks. The note indicated the "edges are a little red but middle is bruising." Tenant #2 did not know where she got the pressure sore. Tenant #2 spent a lot of time in her bed when she was feeling depressed. The service plan would be updated for the sore. The PCP was faxed for orders. The nurse applied Mepliex to the area.

-On 1-4-22 it was noted an order was received to apply Mepliex to the the left buttocks, change every three days, until healed.

-On 2-9-22 it was noted a nurse followed up regarding Tenant #3's buttocks. Her buttocks was "red and beefy looking in circular shape as it was previously. This area was was black looking in the middle when RN first originally saw it. It is looking better." Tenant #3 did not have any pain. It was noted nursing staff would continue to monitor.

Continued record review revealed a fax to the PCP dated 12-7-21 reflected a 90 day assessment was completed and Tenant #3 had lost 11.8 pounds. It was indicated it could be due to her history of depression and not getting out bed on some days.

A fax to the PCP dated 12-30-21 reflected Tenant #3 said that she wanted a knife when staff was

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assisting her with cares. It was noted she had a history of saying "these things but does not have a plan."

A fax to the PCP dated 1-4-22 reflected Tenant #3 had a "golf size stage 2 wound/pressure sore" to the left buttocks. It was most likely from Tenant #3 not moving much and and being in bed some days. An order was received for Mepliex, change every three days until healed.

When observed on 2-15-22 at 11:40 a.m. Staff D administered medications including to Tenant #3. Staff D prepared Tenant #3's liquid medication, fluoxetine (Prozac) 10 milliliters (ml)/40 milligrams (mg). She poured the liquid medication into a medication cup and then mixed it with Tenant #3's milk. It was provided to Tenant #3 at the dining room table during lunch. Staff D signed off the medication after it was provided to Tenant #3.

Continued record review of Tenant #3's February 2022 medication administration record (MARs) reflected an order for fluoxetine (Prozac), give 10 ml (40 mg), liquid medication, mixed with milk daily at lunch (at 12:00 p.m.). The MARs reflected Staff D's initials for the administration of the medication.

Further record review revealed cognitive, health and functional evaluations (annual) were most recently completed on 6-15-21. The last signed service plan was dated 6-15-21 (annual). The service reflected staff administered her medications. The service plan did not reflect staff administered her liquid medication in milk at lunch. The service plan reflected Tenant #3 expressed more depressed comments, "she would rather hurt herself than do stuff to please staff." The service plan did not include Tenant

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#3's comments regarding self harm and interventions. The service plan was updated to reflect a pressure ulcer to the left buttock and to notify nursing staff if the it was weeping, open or if the dressing had come off. No date was provided on the service plan regarding when the update for the pressure ulcer occurred and the service plan update was not based on evaluations as they were not completed. The treatment for the pressure ulcer or other interventions were not included on the service plan. The service plan also did not reflect her weight loss as noted above.

4. Record review on 2-16-22 of Tenant #4's file revealed diagnoses included: Alzheimer's disease and prostate cancer. Tenant #4 was staged at a five on the GDS. Tenant #4 was admitted on 1-24-22 and pre-admission evaluations were completed dated 12-31-21.

Observation notes indicated the following:

-On 1-25-22 it was noted a catheter was placed by hospice and the service plan was updated to reflect staff emptied the catheter every four hours as needed. Tenant #4 had a catheter prior to to admission and had urinary retention. Tenant #4 did not void all afternoon and hospice was alerted and they came on 1-24-22 to place the catheter. The service plan was updated.

-On 1-25-22 it was noted the service plan was updated to reflect staff was to clean Tenant #4's catheter night bag each morning and his day bag each night. Staff assisted with emptying the catheter throughout the day/

-On 1-25-22 it was noted a new order was received to irrigate Tenant #4's catheter as

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A 350	Continued From page 37 needed with sterile water. Continued record review revealed a Physician Order Sheet reflected an order to irrigate the catheter daily as needed with sterile water dated 1-25-22. Further record review revealed the most recent signed service plan dated 1-24-22 reflected a toileting schedule; however, did not reflect catheter care. The current service plan provided (not signed) reflected to clean the catheter bag after day use and to clean the catheter bag after night use. The service plan also reflected Tenant #4 had a catheter in place and to empty the catheter bag every four hours or it it appeared full. Tenant #4 needed assistance to the bathroom for bowel movements. The service plan did not reflect a date of the update to the service plan with catheter and was not based on evaluations as they were not completed. 5. Record review on 2-16-22 and 2-17-22 of Tenant #5's file revealed Tenant #5 was staged at a five on the GDS, which indicated moderately severe cognitive decline. An Annual Assessment dated 1-17-22 reflected staff administered Tenant #5's medications. At times it was difficult to get Tenant #5 to take his medication. Staff was to re-attempt, with a different staff and Tenant #5 usually took his medication. Continued record review revealed A Physician Order Sheet reflected an order for Boost supplement, drink one boost daily with breakfast. Further record review revealed Observation notes indicated the following: -On 12-13-21 it was noted it was a follow up to an	A 350		

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incident report from 12-10-21. Tenant #5 was seated at the dining room table and another tenant yelled. He grabbed her arm and then the other tenant grabbed his arm.

-On 1-14-22 it was noted Tenant #5 had an incident with another tenant that morning. He grabbed her by the arm and pulled it behind her back. Tenant #5 yelled, he was "tired of this crap, I'm the boss around this place."

-On 1-20-22 it was noted Tenant #5 had two episodes of behavior in the last 30 days. The most recent incident occurred on 1-19-22. Tenant #5 was "triggered" as another tenant was yelling at Tenant #1 to sit down as Tenant #1 was wandering around the dining room. Tenant #5 began yelling at Tenant #1 and she yelled back at him. Tenant #5 stood up and threatened Tenant #1 if she did not go away. Tenant #1 refused to move away from the table and called him a "derogatory term" and he physically shoved her. Neither tenant accepted redirection and disregarded staff. Tenant #5 was "combative and aggressive towards anyone who (sic) disagreed with him."

-On 2-9-22 it was noted Tenant #5 had three episodes of behavior in the past several weeks. The most recent behavior was on 2-8-22, staff called and requested a nurse right away. When the nurse went to memory care Tenant #5 was yelling, using profanity and he thought the staff were acting like children and it was "play time" for them. Tenant #5 was upset another tenant was closing his eyes at the table. Tenant #5 yelled at the staff and acted like he was going to punch one of the staff in the face. Tenant #5 did not hit anyone during the incident.

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A 350	Continued From page 39 Continued record review revealed the service plan did not reflect Tenant #5's medication refusals and interventions, or the boost supplement given daily. The service plan reflected behavior with Tenant #5, including behavior with Tenant #1 in memory care. The service plan reflected history of agitation and indicated at times Tenant #5 might be combative. The service plan did not reflect at times the behaviors were physical towards another tenant and the increase in episodes of behavior. 6. When interviewed on 2-21-22 at 12:38 p.m. the Executive Director confirmed the most current service plans were provided for the tenant listed above.	A 350		
A 430	481-69.27(1)c 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 review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse reviews as needed when there was a change in tenants' health status. This pertained to 2 of 2 tenants	A 430		

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A 430	Continued From page 40	A 430		

reviewed with wound care (Tenants #3 and #5). Findings follow:

1. Record review on 2-16-22 of Tenant #3's file revealed a diagnosis of Alzheimer's disease. Tenant #3 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline.

A Staff/Nurse Communication Report form dated 1-1-22 reflected staff reported change in Tenant #3's skin integrity. The form indicated a pressure ulcer was noted to the lower left buttock and Mepliex was applied by staff.

Continued record review revealed Observation notes indicated the following:

-On 1-4-22 (nurse review) it was noted a nurse followed up on a staff to nurse communication report related to a sore on Tenant #3's left buttocks. Tenant #2 had a stage 2 pressure sore on her buttocks. The note indicated the "edges are a little red but middle is bruising." Tenant #2 did not know where she got the pressure sore. Tenant #2 spent a lot of time in her bed when she was feeling depressed. The service plan would be updated for the sore. The primary care provider (PCP) was faxed for orders. The nurse applied Mepliex to the area.

-On 1-4-22 it was noted an order was received to apply Mepliex to the the left buttocks, change every three days, until healed.

-On 2-9-22 it was noted a nurse followed up regarding Tenant #3's buttocks. Her buttocks was "red and beefy looking in circular shape as it was previously. The area was was black looking in the middle when RN first originally saw it. It is

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looking better." Tenant #3 did not have any pain. It was noted nursing staff would continue to monitor.

Further record review revealed a fax to the PCP dated 1-4-22 reflected Tenant #3 had a "golf size stage 2 wound/pressure sore" to the left buttocks. It was most likely from Tenant #3 not moving much and and being in bed some days. An order was received for Mepliex, change every three days until healed.

Continued record review revealed from 1-4-22 to 2-9-22, there were no documented nurse reviews related to the monitoring of Tenant #3's stage 2 pressure ulcer on her left buttocks.

2. Record review on 2-16-22 and 2-17-22 of Tenant #5's file revealed a diagnoses included peripheral vascular disease and diabetes mellitus. Tenant #5 was staged at a five on the GDS, which indicated moderately severe cognitive decline.

Observation notes indicated the following:

-On 11-26-21 it was noted the skin tear on Tenant #5's elbow had gotten larger and there were band-aids over the skin tear, when they removed the skin tear increased in size. The area surrounding the skin tear was open, red, bleeding when there was not a dressing over it. It was "starting to look bad." The nurse sent pictures to Tenant #5's family, so she could send them via an electronic patient file system, to the PCP. The nurse applied Mepilex.

-On 11-29-21 it was noted the nurse received a note from staff related to the Mepliex dressing on Tenant's left elbow on 11-28-21. Staff noted a

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build up of blood under the Mepliex dressing (applied on Friday). When the Mepliex was removed, the wound bled "a decent amount" and staff was able to stop the bleeding with pressure.

-On 11-30-21 it was noted a fax was received from the PCP related to Tenant #5's left elbow treatment. A note was made to call the office and have the provider paged as faxes were not received over the weekend or holidays.

-On 12-1-21 it was noted orders were received to treat with triple antibiotic ointment (TAO), non-stick pad, to wrap with stretch gauze and secure with tape. The dressing was ordered to be changed daily and as needed until healed. If the area did not improve, Tenant #5 would need to be seen in the office.

-On 12-13-21 it was noted when visiting with Tenant #5 a nurse noted the skin tear to his left elbow was healed. The service plan was updated.

-On 12-14-21 it was noted the skin tear to Tenant #5's left elbow was healed and the treatment was discontinued. The PCP was notified.

Continued record review revealed a fax to the PCP dated 11-12-21 indicated Tenant #5 was sent out to the emergency department (ED) and returned. He had a quarter size skin tear on his outer left elbow. An order was received for TAO and band-aid, change daily until healed.

A fax to the PCP dated 11-26-21 indicated Tenant #5's left elbow area had a big skin tear that was red and bleeding when it was left open to air. The skin was "ripped off area." Above that area there were "two other areas that don't look great."

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A 430	Continued From page 43 A fax to the PCP dated 11-30-21 indicated an order was received for TAO, a non-stick pad, wrap with stretch gauze and secure with tape. The wound was to be changed daily and as needed until healed. Further record review revealed from 12-1-21 to 12-13-21, there were no documented nurse reviews related to Tenant #5's elbow wound. Continued record review revealed an Incident Report dated 12-29-21 reflected Tenant #5 called for assistance and staff observed him sitting in the chair and noticed blood on the other chair and floor. Tenant #5 said he fell and got himself up. Tenant #5 wanted his arm wrapped and cleaned. Tenant #5's right arm "had many large skin tears where the skin is totally missing." Further record review revealed Observation notes indicated the following: -On 12-30-21 it was noted a nurse followed up from an incident report from 12-29-21. Tenant #5 had told staff he had fallen and gotten back up. Tenant #5 had multiple skin tears to his right arm. He requested the staff wrap his arm for him. The skin tears were cleansed and dressed. Family was notified and the nurse was waiting for orders from the PCP. -On 12-30-21 it was noted orders were received to cleanse and change the dressing every other day. If there was any sign of infection to have him seen in clinic. -On 1-3-22 it was noted a nurse assisted staff with changing Tenant #5's dressing. The bandage was "stuck so RN soaked with saline	A 430		

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wound cleaner to remove." The wound was cleansed, dried and TAO was applied. Non-stick gauze was applied and telfa were secured with tape. The wounds appeared to be infected and a drainage cream in color was noted. The PCP was notified.

-On 1-4-22 it was noted a fax was received the PCP requested Tenant #5 been seen. A telehealth appointment was set up.

-On 1-4-22 it was noted a a new order was received for Cephalexin 500 milligram (mg), three times daily for 10 days.

-On 1-7-22 it was noted a nurse received a staff communication report from 1-7-22. The report indicated Tenant #5 was scratching at the bandage on his arm and he reported it "itched really bad." Tenant #5 was being treated for an infection to the skin tears and had the bandage changed every other day.

-On 2-14-22 it was noted a nurse observed Tenant #5's the skin tears on his right forearm. The area continues to improve and it was noted the surrounding area was "pink in color other than scar tissue." Tenant #5's skin was intact.

Continued record review revealed a fax to the PCP dated 1-3-22 indicated Tenant #5's right arm skin tears appeared to be infected. It was noted there was "thick cream colored drainage" and Tenant #5's right hand appeared slightly swollen. The PCP requested Tenant #5 be seen the following day.

Further record review revealed from 1-7-22 to 2-14-22 there were no documented nurse reviews related to Tenant #5's wound and infection. An

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A 430	Continued From page 45 annual evaluation was completed on 1-17-22 and it indicated a nurse had observed the skin tears to the right arm and they appeared to be healing and scabbed. A nurse review was not completed when the antibiotics were completed and nurse reviews were not completed related to monitoring of the wound and infection. 3. When interviewed on 2-21-22 at 12:38 p.m. the Executive Director said it was up to nurse discretion regarding the frequency of wound monitoring.	A 430		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to have staff complete eight hours of dementia training within 30 days of employment. This pertained to 2 of 4 staff reviewed that were hired in 2021 (Staff A and Staff B). Findings follow: 1. Record review on 2-14-22 of Staff A's training documents revealed Staff A was hired on 8-8-21. Staff A had eight hours of dementia education completed; however, it was not completed within 30 days of hire.	A 545		

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A 545	Continued From page 46 2. Record review on 2-14-22 of Staff B's training documents revealed Staff B was hired on 12-28-21. Staff B had eight hours of dementia education completed; however, it was not completed within 30 days of hire. The Program provided additional training documents for Staff B, including a Caregiver Skills Checklist dated 12-30-21; however, the Memory Care Door Alarms section on the document was not initialed as completed. A Welcome to the Keystone Cedars Memory Care document was also provided; however, the document was not dated and a length of time to complete was not indicated on the document. 3. When interviewed on 2-21-22 the Executive Director indicated Staff B had additional dementia training (see above). She said Staff B also had 7.5 hours on the online transcript.	A 545		

OK
5-9-22

Keystone Cedars Memory Care
Plan of Correction
May 2, 2022

A150 – Program Policies and Procedures 481-67.2(3)

Findings:

1. Program failed to follow its policy and procedure related to the completion of incident reports.

Plan of Correction:

1. The program has updated its paper Incident Report Form to faciliate ease of prompt completion by staff members (a copy of which is attached as Exhibit 1). All staff will be retrained on completion of Incident Reports and where within the establishment blank Incident Report Forms are available. Retraining will be completed by May 15, 2022. Incident Report Forms should be completed in the electronic charting system, ECP, by the designated Health and Wellness supervisor for the particular shift. Health and Wellness staff will be retrained on utilization of ECP for completion of Incident Report Forms. In addition, the program is in the process of updating its electronic Incident Report Form to facilitate efficiency in completion.

2. The program has amended it policy Incident Reporting Policy and Procedure (a copy of which is attached as Exhibit 2). The policy has been updated to specify additional situations in which staff are to complete an Incident Report Form and further identify the requiremet for completion of Incident Report Forms in situations which may be ordinary or common events concerning a particular resident but are of a significance that require an Incident Report.

3. The program has amended its policy Behaviors – Physical Agression as of April 29, 2022 (a copy of which is attached as Exhibit 3). The policy has been updated to address situations such as that which resulted in the Finding wherein the resident has a pattern of aggressive behaviors.

4. All Health and Wellness staff will be retrained with respect to the new Incident Report Form, the updated Incident Reporting Policy dated April 29, 2022 and Procedure and the updated Behaviors – Physical Agression Policy and Procedure dated April 29, 2022. Retraining will be completed by May 18, 2022.

5. The Executive Director has conducted further review and testing of the memory care door alarm system to ensure it works properly. There has been no indication at any point that the memory care door alarm system does not function properly. At any time the Executive Director determines that the system may not be operating properly, the Executive Director shall contact the third party vendor of the system and engage a thorough on-site review and determination of any mechanical, hardware or sofware problems. The Executive Director shall ensure that any needs repairs or replacements are ordered promptly.

A 155 – Tenant Rights 481-67.3(1)

Findings:

1. The program failed to meet tenant rights by failure to be treated with personal dignity, respect and autonomy.

Plan of Correction:

1. The program will continue to utilize its' judgment in the circumstances to determine the reliability of reported incidents. The program has updated its Incident Report Form (a copy of which is attached as Exhibit 1) to provide ease of reporting so that when an alleged incident occurs, staff members have a prompt avenue for reporting the alleged incident. Additionally all Health and Wellnes staff will be retrained on completion of Incident Reporting within ECP, the program's electronic charting system. Prompt reporting will assist the program with prompt investigations so that reports may be promptly substantied or identified as unsubstantiated. The Incident Report Form emphasisizes documentation of notification of family members/representatives and documentation of attempts to contact a family member. All staff will be retrained on completion of Incident Reports via paper or electronic, and where within the establishment blank paper Incident Report Forms are available. Retraining will be completed by May 18, 2022.

2. All Health and Wellness staff will be retrained with respect to the new Incident Report Form, completion of electronic Incident Report Forms and the updated Incident Reporting Policy dated April 29, 2022. Retraining will be completed by May 18, 2022.

3. All staff will be retrained on Tenant Rights. Retraining will be completed by May 18, 2022.

4. All staff will be retrained in the Keystone Family Philosphy for a Healty Culture on page 2 of the employee handbook and the KSMS Standards of Conduct as set forth on page 3 of the employee handbook, particularly the provisions relating to Teamwork and Self Management. The Executive Director, Director of Health and Wellness and the Director of Operations will continue to monitor staff to verify staff respect one another and proper reporting of incidents occurs with facts only and without hyperbole or conclusary assertions in an effort to cause disciplinary action to be taken towards a co-worker.

A361- Staffing 481-67.9(4)

Findings:

1. Regarding nurse delegation procedure, the program failed to ensure staff provided services in accordance with training provided.

Plan of Correction:

1. The program has revised its Medication Needs of Tenants/Medication Management Policy and Procedure effective as of April 29, 2022 (a copy of which is attached as Exhibit 4).

2. All staff will be trained on the Medication Needs of Tenants/Medication Management Policy and Procedure no later than May 18, 2022.

A145 - Evaluation of Tenant 481-69.22(3)

Findings:

1. Program failed to complete evaluations as needed with significant change.

Plan of Correction:

1. The Program has updated its Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure as of April 29, 2022 (a copy of which is attached as Exhibit 5). The updated policy includes a list (which is not comprehensive) of changes to a tenant's condition that would be considered a significant change and necessitate an evaluation and service plan change.

2. The Director of Health and Wellness will ensure that all Health and Wellness staff shall be retrained in the updated Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure by May 18, 2022.

3. All Health and Wellness staff will be retrained by on the Community's electronic charting system which includes automated alerts for resident assessments. The Chief Experience Officer will assist the Director of Health and Wellness with tools in ECP that will provide for efficiency for changes to service plans. The program has modified its ECP assessments/service plans to provide for history of falls and behaviors for ease of reference.

A160 – Criteria for Admission/Retention of Residents 481-69.23(1) c(1)

Finding:

1. The program failed to discharge a tenant that exceeded the level of care.

Plan of Correction:

1. The Executive Director shall perform a review of all Incident Reports on a monthly basis for the purpose of determination of patterns of behavior that might necessitate re-evaluation of the appropriateness of a tenant for continued residency with Keystone Cedars. While the program has long viewed its role as a service to residents and families where resident behaviors are manageable or can, with the assistance of the primary health care provider be easily modfied, the program will upon identification of repeat exit seeking or aggressive behaviors, the program will accelerate residents' discharge from the program. Any tenant requirng one on one assistance (other than occasionally) will be discharged from the program.

A 350 – Service Plans 481-69.26(4)

Findings:

1. Program failed to complete service plans as needed and failed to develop service plans to reflect the identified needs of tenants and preferences for assistance. Program failed to modify service plans to include all service changes even temporary and failed to modify service plans to show frequency of condition or incidents.

Plan of Correction:

1. The Program has updated its Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure as of April 29, 2022 (a copy of which is attached as Exhibit 5). The updated policy includes a list (which is not comprehensive) of changes to a tenant's condition that would be considered a significant change and necessitate an evaluation and service plan change.

2. The Director of Health and Wellness will ensure that all Health and Wellness staff shall be retrained in the updated Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure by May 18, 2022.

3. All Health and Wellness staff will be retrained by on the Community's electronic charting system which includes automated alerts for resident assessments. The Chief Experience Officer will assist the Director of Health and Wellness with tools in ECP that will provide for efficiency for temporary changes. The Chief Experience Officer and Executive Director will review the electronic service plan form to identify areas of improvement and methods to facility ease of use. The program has modified its ECP assessments/service plans to provide for history of falls and behaviors for ease of reference. The Chief Experience Officer will train the Executive Director and Director of Health and Wellness on tools within ECP that allow for temporary changes in a service plan with automated alerts to revise.

4. The Executive Director shall perform a review of all Incident Reports on a monthly basis for the purpose of determination of incidents that would necessitate an revision in the tenant's service plan. The Executive Director will then review tenant records to determine whether service plan revisions have been made and coordinate with the Director of Health and Wellness to revise service plans as needed.

A430 – Nurse Review 481-69.27

Findings:

1. The program failed to complete nurse reviews as needed when there was a change in tenants' health status.

Plan of Correction:

1. The Program has updated its Nurse Review Policy and Procedure as of April 29, 2022 (a copy of which is attached as Exhibit 6). The updated policy includes specific requirements with respect to wound care.

2. The Executive Director who is an RN shall review the updated Nurse Review Policy and Procedure with the Director of Health and Wellness and the Executive Director and the Director of Health and Wellness shall retrain all nursing staff on the updated Nurse Review Policy and Procedure. Review and retraining will be completed by May 18, 2022.

A545 – Dementia Specific Education for Personnel 481-69.30(1)

Findings:

1. Program failed to properly complete eight hours of dementia training within 30 days of employment.

Plan of Correction:

1. The Program has updated its Personnel File Checklist to include a checklist for Orientation Training. The Orientation Training includes dementia specific training.

2. The Program has amended its' Staff Training Policy and Procedure as of April 29, 2022 (a copy of which is attached as Exhibit 7). The Director of Operations and the Director of Health and Wellness will be retrained on the revised Staff Training Policy and Procedure no later than May 6, 2022.

3. The Director of Operations shall conduct audits of the personnel files including verification of training and documentation of training at the intervals set forth on the Staff Training Policy and Procedure and ensure that any training is completely on a timely basis in accordance with regulatory requirements and the policy and procedure.