

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STONEY POINT MEADOWS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 STONEY POINT ROAD SW CEDAR RAPIDS, IA 52404</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	<p>Initial Comments</p> <p>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.</p> <p>General Population Number of tenants without cognitive disorder: 64 Number of tenants with cognitive disorder: 3</p> <p>Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 8</p> <p>Total Census of Assisted Living Program for People with Dementia: 75</p> <p>The investigation of Incident #98416-I and Complaint #105445-C and the recertification visit to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program were completed and the following regulatory insufficiencies were identified:</p> <p>This is an AMENDED Statement of Deficiencies.</p>	A 000		
A 150	<p>481-67.2(3) Program Policies and Procedures</p> <p>67.2(3) The program shall follow the policies and procedures established by the program.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow its policy related to incident reports for 3 of 7 current (Tenants #1, #2 and #4) and 1 of 1 former tenants reviewed (Tenant C1) and failed to follow its policy</p>	A 150		

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

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STONEY POINT MEADOWS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 STONEY POINT ROAD SW CEDAR RAPIDS, IA 52404</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 1</p> <p>regarding a prompt response to pendants. This potentially affected all tenants in the general population unit (census of 67). Findings follow:</p> <p>1 a. Review of Tenant #1's and Tenant #2's files on 6-29-22 and 7-11-22 revealed on 6-1-22 they spent a lot of time together and visited each other's apartments. They were asked to stay in a common area but at some point staff noted they were not there. The tenants were found in Tenant #2's apartment engaged in sexual intercourse. Staff intervened and contacted the Director of Health Services to come to the memory care unit. The tenants both stated the act was consensual. As both tenants had a Global Deterioration Scale score of 5 indicating moderately severe decline, families were contacted.</p> <p>An incident report was not completed related to the incident on 6-1-22 and a witness statement was not completed by staff who witnessed the incident.</p> <p>b. When interviewed on 7-12-22 at approximately 10:00 a.m. Tenant #4 reported she moved into the Program in March of 2022. She had put a check in the bank and kept \$1000.00 out and spent some of it. She had approximately \$600.00 left and put the money in specific location in her apartment. She heard from other tenants at a resident meeting there were things missing. She checked where the money was stored and it was gone. She reported it to the Director of Housing. The Director of Health Services also interviewed her. She had not heard anything else about it and felt they questioned the accuracy of what she reported. She had not had anything else missing.</p> <p>On 7-13-22 the Director of Health Services and the Director of Housing both confirmed speaking</p>	A 150	<div style="border: 1px solid blue; padding: 10px; width: fit-content; margin: auto;"> <p>Tag A 150Program will complete an incident</p> </div>	

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STONE POINT MEADOWS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 STONEY POINT ROAD SW CEDAR RAPIDS, IA 52404</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 2</p> <p>to the tenant about her missing money. They stated there was no documentation or an incident report completed regarding the tenant's concern of missing money.</p> <p>c. Review of Tenant C1's file on 7-12-22 and 7-13-22 revealed Tenant C1 was admitted on 11-5-20 and died on 7-3-21. A Resident Note dated 7-3-21 indicated staff called Nurse #1 at 4:41 p.m. and reported Tenant C1 was found "unresponsive, covered in blood, lying in his bed in the apartment, 911 has been called." Ambulance, fire department and police arrived. The police report dated 7-3-21 concluded the tenant had committed suicide.</p> <p>Continued record review revealed an incident report was not completed related to Tenant C1's suicide. Additionally, statements were not completed by staff involved in the incident.</p> <p>d. Review of the Program's policy and procedure related to the completion of incident reports indicated all accidents or unusual occurrences would be reported as incidents. The person in charge at the time of the incident would complete the incident report form. The incident report would include written statements from those who witnessed the incident.</p> <p>2. A community meeting was held with approximately 20 tenants on 7-11-22 at 2:30 p.m. One tenant said it took 10 minutes for staff to respond when the tenant's spouse had a medical issue. The pendant responses took longer later in the evenings.</p> <p>Pendant times were reviewed and indicated the following: - On 7-1-22 at 8:28 a.m. a pendant was</p>	A 150	<p>Tag A 150</p> <p>Program will complete an Incident report which includes a witness statement with any unusual occurrence. Program will follow Policy .</p> <p>Measure Tag 150</p> <p>Educate with all Staff on Policy and procedure to complete an incident report.</p> <p>Monitor Tag 150</p> <p>Tenant reviews accomplished by DON and Management (Casia).</p> <p>Date of correction- Sept 1st 2022</p>	

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STONEY POINT MEADOWS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 STONEY POINT ROAD SW CEDAR RAPIDS, IA 52404</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 3</p> <p>activated and was not reset (responded to) for 19 minutes and 46 seconds.</p> <ul style="list-style-type: none"> <li>- On 7-1-22 at 4:53 p.m. a pendant was activated and was not reset for 24 minutes and 34 seconds.</li> <li>- On 7-2-22 at 6:55 p.m. a pendant was activated and was not reset for 47 minutes and 8 seconds.</li> <li>- On 7-4-22 at 4:40 p.m. a pendant was activated and was not rest for 38 minutes and 50 seconds</li> <li>- On 7-7-22 at 8:33 a.m. a pendant was activated and was not reset 15 minutes and 51 seconds.</li> </ul> <p>The Program's policy and procedure regarding pendants indicated it was the policy to respond to "summoning devices" call lights, call cords "promptly."</p> <p>On 7-19-22 at 3:23 p.m. the Director of Housing indicated there was not a specific timeframe in the policy and procedure related to the pendant response.</p>	A 150	<p>Tag 150 Penant</p> <p>As of August 2022 program has a new pendant system that will alert caregivers every 2 minutes until pendant is turned off.</p> <p>Monitor Tag 150 Pendant</p> <p>Program will review response time with the tentants.</p> <p>Date of correction- August 25th 2022</p>	
A 361	<p>481-67.9(4)f Staffing</p> <p>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 shall, at a minimum, include the following:</p> <p>f. Services shall be provided to tenants in accordance with the training provided.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record</p>	A 361		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STONEY POINT MEADOWS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 STONEY POINT ROAD SW CEDAR RAPIDS, IA 52404</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 361	<p>Continued From page 4</p> <p>review the Program failed to ensure staff provided services in accordance with training provided affecting 1 of 1 tenants observed receiving a blood glucose check (Tenant #1). Findings follow:</p> <p>When observed on 6-29-22 at approximately 11:45 a.m. Staff D assisted Tenant #1 with his blood glucose check in the office located near the entrance to the memory care unit. She removed her gloves and took the supplies, including the lancet, and walked through a common area to the other hallway to dispose of the materials in the sharps container on the medication cart.</p> <p>Review of Staff D's training documents revealed a hire date of 10-5-21. Staff D received training on blood glucose testing dated 10-16-21. The training included to gather supplies including a sharps container, dispose of the lancet in the sharps container after usage and then remove and dispose of gloves.</p> <p>On 7-13-22 the Director of Health Services said she expected staff to dispose of the needle in the sharps container before removing gloves. She confirmed Staff D had training on blood glucose monitoring.</p>	A 361	<p>Tag A 361</p> <p>Program will review educate proper Blood Glucose Training with the individual that was observed . Program will continue to train all Caregivers on proper Blood Glucose Testing.</p> <p>Montior Tag 361</p> <p>Nursing will observe caregivers as needed to assure staff member is following the correct procedures.</p> <p>Date of Correction Aug.25th 2022</p>	
A 350	<p>481-69.26(1) Service Plans</p> <p>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.</p>	A 350		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STONEY POINT MEADOWS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 STONEY POINT ROAD SW CEDAR RAPIDS, IA 52404</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 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed for 5 of 7 of tenants reviewed (Tenants #1, #3, #5, #6 and #7). Findings follow:</p> <ol style="list-style-type: none"> <li>Review of Tenant #1's file on 6-29-22 and 7-11-22 revealed diagnoses included type 2 diabetes mellitus (DM) without complications and congestive heart failure (CHF). Tenant #1 was staged a a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant #1 resided in the memory care unit.</li> </ol> <p>Resident Notes indicated the following:</p> <ul style="list-style-type: none"> <li>On 6-12-22 staff reported Tenant #1's right first toe was bleeding at the toe nail and it appeared to be loose. He pulled off his sock for his shower and the toe nail pulled when the sock was removed. His toe and foot were swollen and red. Tenant #1 complained of pain. Family was notified and it was requested Tenant #1 be seen in the emergency room (ER).</li> <li>On 6-13-22 Tenant #1 was admitted to the hospital and there were concerns related to a CHF exacerbation.</li> <li>On 6-16-22 the tenant returned to the Program after being treated for CHF. His toenail had been removed and a Mepilex dressing was in place.</li> <li>On 6-16-22 the provider was called to provide clarification of orders on the After Visit Summary. The provider ordered to hold the 70/30 insulin until she reviewed hospital records. Orders were received to continue mealtime Novolog with the same parameters and continue with daily weights and parameters. It was also ordered to cover the</li> </ul>	A 350	<p>Tag A 350</p> <p>Program will Educate Nurse regarding Service plan updates when changes have occurred.</p> <p>Tag A 350 Monitored</p> <p>Tendant reviews will be accomplished by DON and Management (Cassia).</p> <p>Tag A 160 Correction Date Sept 1st 2022.</p>	

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STONEY POINT MEADOWS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 STONEY POINT ROAD SW CEDAR RAPIDS, IA 52404</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 6</p> <p>right great toe wound with a non-adhesive dressing. The dressing was to be changed daily until there was no drainage. At that point the toe was to be left uncovered to open air.</p> <p>-On 6-21-22 it was noted the right great toe did not have draining and the nail bed was dry. The dressing was removed and the toe was left open to air per order. The dressing supply was removed from the medication cart.</p> <p>Tenant #1's Master Care Plan dated 6-7-22 was not updated to reflect the issue with the right great toe and dressing change. The Master Care Plan still reflected therapy services. Occupational therapy (OT) and physical therapy (PT) were discontinued on 6-30-22 and the service plan was not updated when the services were discontinued.</p> <p>2. Review of Tenant #3's file on 7-11-22 revealed diagnoses including Alzheimer's disease and physical deconditioning. Tenant #3 was staged at six on the GDS, which indicated severe cognitive decline. Tenant #3 resided in the memory care unit.</p> <p>Resident Notes dated 5-6-22 indicated orders were received for PT/OT. These services were discontinued on 6-16-22. The tenant's Master Care Plan dated 4-23-22 was not updated when these services were provided.</p> <p>3. Review of Tenant #5's file on 7-12-22 and 7-13-22 revealed diagnoses including bipolar disorder and dementia.</p> <p>Resident Notes indicated the following: - On 4-25-22 Tenant #5 reported she felt suicidal. She did not come out for supper in the dining room. She felt sad related to a situation</p>	A 350		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STONEY POINT MEADOWS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 STONEY POINT ROAD SW CEDAR RAPIDS, IA 52404</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 7</p> <p>with her family but denied a plan for suicide. The nurse requested Tenant #5 be seen in the ER but she declined. Comfort checks were added to the service plan.</p> <ul style="list-style-type: none"> <li>- On 4-26-22 Tenant #5 reported having a "rough time." She had written a letter to a family member and the family member was upset about what was written. Tenant #5 denied that she needed to be seen urgently related to suicidal ideations. It was suggested that she talk to her counselor.</li> <li>- On 4-27-22 a nurse with the doctor's office called and reported Tenant #5 had called the office and said she was feeling suicidal but refused to go to the ER. A nurse went to her apartment and she said she had a lot on her mind. Tenant #5 said she was upset with a family member. She denied a plan for self-harm. Tenant #5 said she was just thinking about suicide but medication could fix it and she had contacted her doctor to increase doses. The nurse recommended the ER but Tenant #5 declined again.</li> <li>- On 5-1-22 Tenant #5 went to church that day and had been dressing and coming to meals that weekend. Tenant #5 used her lorazepam as needed for anxiety. Comfort checks would be removed from her service plan.</li> <li>- On 5-2-22 Tenant #5 struggled again and said her as needed lorazepam was not working. She was tearful and voiced family issues. It was recommended that she be seen (in the ER) and she agreed it would be helpful.</li> <li>- On 5-2-22 Tenant #5 returned to the Program with no changes in meds. She was given a phone number she could call if she needed someone to talk to.</li> <li>- On 7-7-22 a 90 day review was completed. An antifungal cream (Baza cream) was ordered for a groin rash. Tenant #5 denied suicidal thoughts</li> </ul>	A 350		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STONEY POINT MEADOWS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 STONEY POINT ROAD SW CEDAR RAPIDS, IA 52404</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 8</p> <p>and said she felt happy and much better. Her medications had been adjusted and no adverse side effects were noted.</p> <p>The Master Care Plans dated 4-12-22, 5-26-22 and 7-7-22 reflected Tenant #5 had history of depression and had an as needed medication for anxiety. It reflected Tenant #5 had a psychiatrist. The service plan did not include interventions if Tenant #5 voiced she was suicidal.</p> <p>4. Review of Tenant #6's file on 7-12-22 and 7-13-22 revealed diagnoses including Alzheimer's disease, recurrent major depressive disorder and acoustic neuroma. Tenant #6 was staged a five on the GDS, which indicated moderately severe cognitive decline. Tenant #6 resided in the memory care unit.</p> <p>Resident Notes indicated the following:</p> <ul style="list-style-type: none"> <li>- On 6-14-22 staff reported to a nurse that Tenant #6 had choked and she had to provide the Heimlich maneuver. Tenant #6 was seated in the dining room and was eating dessert. She noticed his breathing was abnormal and realized he was choking. She was able to stop the choking with the Heimlich maneuver. Tenant #6 returned to his baseline. His legal representative was notified and declined for him to be sent out for evaluation. Temporary comfort checks were added.</li> <li>- On 6-15-22 a 90 day review was completed. Tenant #6 had a choking episode the day prior. The assessment indicated Tenant #6 was very hard of hearing (HOH), he "cannot stand loud sounds or too much stimulation."</li> <li>- On 6-27-22 staff found a knife in Tenant #6's apartment. The legal representative was contacted to come by and pick it up.</li> </ul> <p>Continued record review revealed the Master</p>	A 350		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STONEY POINT MEADOWS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 STONEY POINT ROAD SW CEDAR RAPIDS, IA 52404</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 9</p> <p>Care Plan dated 6-14-22 did not reflect the choking episode or the knife found in Tenant #6's apartment. The service plan reflected he was HOH but did not reflect Tenant #6 strongly disliked loud noises.</p> <p>5. Review of Tenant #7's file on 7-13-22 revealed diagnoses including end stage renal disease and type 2 diabetes. The Master Care Plan dated 6-23-22 reflected Tenant #7 went to dialysis three days per week.</p> <p>Resident Notes indicated the following:                      - On 6-2-22 a fax was received from the dialysis center requesting the tenant increase protein/caloric intake via supplement if available and to send sevelamer (medication) with him for lunch on days he went to dialysis. A call was placed to Tenant #7's family to request nutritional shakes be provided and kept in his refrigerator. The medication list was updated to reflect sevelamer to be sent out with Tenant #7 for the noon meal on days he went to dialysis.                      - On 7-12-22 a 90 day review was completed. Tenant #7 received dialysis three times per week. He started drinking nutritional/protein shakes as recommended by dialysis.</p> <p>The tenant's Master Care Plans dated 6-23-22 and 7-12-22 did not reflect the nutritional/protein shakes or that sevelamer was sent with Tenant #7 on the days he went to dialysis.</p> <p>6. When interviewed on 7-13-22 the Director of Health Services confirmed the all of the service plans in the time period requested were provided for the tenants reviewed.</p>	A 350		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STONEY POINT MEADOWS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 STONEY POINT ROAD SW CEDAR RAPIDS, IA 52404</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 545  A 545	Continued From page 10  481-69.30(1) Dementia Specific Education for Personnel  69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.  This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure eight hours of dementia-specific training was completed within 30 days of employment for 3 of 8 staff reviewed (Staff D, G and H). Findings follow:  Review of Staff D's training documents on 6-29-22 revealed a hire date of 10-5-21. Staff D did not have eight hours of dementia education completed within 30 days of employment.  Review of Staff G's training documents on 6-29-22 revealed a hire date of 3-16-22. Staff G did not have eight hours of dementia education completed within 30 days of employment.  Review of Staff H's training documents on 6-29-22 revealed a hire date of 4-20-22. Staff H did not have eight hours of dementia education completed within 30 days of employment.  On 7-13-22 at 4:06 p.m. the Director of Housing confirmed this finding.	A 545  A 545	Tag 545  Program has 6 hours of Relias Dementia training and 2 hours face to face training established. We have implemented that the 6 hours of relias has to be accomplished before employee is able to work the position hired. We will have 2 Hour face to face Dementia Training the 2nd Wed. of every month to assure that all employees have eight hours of Dementia Specific training.  Tag 545 This will be monitored by HR and the manager of the departments Chart reviews accomplished by HR.  Date of the correction- Sept 1st 2022.	
A 565	481-69.30(5) Dementia Specific Education for Personnel	A 565		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STONE POINT MEADOWS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 STONEY POINT ROAD SW CEDAR RAPIDS, IA 52404</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 565	<p>Continued From page 11</p> <p>69.30(5) Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, Web-based training, and case studies of tenants in the program</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to include two hours of hands-on instruction to 5 of 5 staff reviewed who had completed eight hours of dementia-specific training within 30 days of employment (Staff A, B, C, E and F). Findings follow:</p> <p>Review of Staff A's training documents on 6-29-22 revealed a hire date of 3-23-22. Staff A had completed the required eight hours of dementia-specific education within 30 days; however, the training provided did not include any documented hands-on instruction.</p> <p>Review of Staff B's training documents on 6-29-22 revealed a hire date of 2-9-22. Staff B had completed the required eight hours of dementia-specific education within 30 days; however, the training provided did not include any documented hands-on instruction.</p> <p>Review of Staff C's training documents on 6-29-22 revealed a hire date of 7-7-21. Staff C had completed the required eight hours of dementia-specific education within 30 days; however, the training provided did not include any documented hands-on instruction.</p> <p>Review of Staff E's training documents on 6-29-22 revealed a hire date of 1-27-22. Staff E had completed the required eight hours of</p>	A 565		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0405</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STONE POINT MEADOWS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 STONEY POINT ROAD SW CEDAR RAPIDS, IA 52404</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 565	<p>Continued From page 12</p> <p>dementia-specific education within 30 days; however, the training provided did not include any documented hands-on instruction.</p> <p>Review of Staff F's training documents on 6-29-22 revealed a hire date of 5-12-21. Staff F had completed the required eight hours of dementia-specific education within 30 days; however, the training provided did not include any documented hands-on instruction.</p> <p>On 7-13-22 at 4:06 p.m. the Director of Housing confirmed all dementia education for the staff listed above was provided.</p>	A 565		