

## DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0415</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/25/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGE GROVE PLACE - CONNECTIONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2115 1ST AVENUE SE CEDAR RAPIDS, IA 52402</b>	
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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: 4 Number of tenants with cognitive disorder: 6  TOTAL Census of Assisted Living Program for People with Dementia: 10  There were no regulatory insufficiencies cited during the onsite infection control survey. A comment was made to the Program regarding recommended guidance for personal protective equipment. Complaint #94412-C and Incident #94539-I were also investigated and the following regulatory insufficiencies were identified:	A 000	See Attached  POC 7/6/21
A 140	481-69.22(2) Evaluation of Tenant  69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change.  This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 2 of 2 tenants reviewed (Tenants #1 and #2). Findings follow:  1. Record review on 3-23-21 of Tenant #1's file	A 140	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 140	<p>Continued From page 1</p> <p>revealed no diagnoses were found in Tenant #1's file. Tenant #1 was staged at a three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline.</p> <p>Continued record review revealed the service plan dated 11-5-20 indicated on 10-31-20, Tenant #1 removed his electronic wandering monitoring device, took the elevator to the lower level parking garage and walked to a pharmacy. Tenant #1 was located and brought back to the Program. He did not sustain any injuries. The electronic wandering monitoring device was placed back on Tenant #1 and 15 minute checks were initiated.</p> <p>The service plan dated 3-2-21 reflected on 11-4-21 a key pad was added to the elevator. If Tenant #1 removed the electronic wandering monitoring device, the elevator could not be accessed without the key pad code. On 2-2-21 an order was received from Tenant #1's physician to reduce monitoring checks to 30 minutes for three weeks. On 2-18-21 the service plan reflected Tenant #1 followed a staff out of the door and was redirected back to the unit. On 2-24-21 a new order was received to reduce monitoring checks to one hour.</p> <p>Further record review revealed service plans dated 11-5-20 and 3-2-21 were updated as needed with significant change; however, evaluations were not completed as needed with significant change when Tenant #1 left the building without staff knowledge and when additional interventions were implemented.</p> <p>2. Record review on 3-23-21 of Tenant #2's file revealed diagnoses included: abnormalities of gait and mobility, spinal stenosis, age related</p>	A 140		

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A 140	<p>Continued From page 2</p> <p>osteoporosis, acute pain due to trauma, personal history of fall, neuropathy and osteoarthritis. Tenant #2 was staged at a five on the GDS, which indicated moderately severe cognitive decline.</p> <p>Continued record review revealed Clinical Notes Report indicated the following:</p> <p>-On 1-26-21 it was noted staff found Tenant #2 lying on the floor on the right side, holding himself up against the wall. Tenant #2 was assisted up with the assistance of two staff and a gait belt into a wheelchair. Tenant #2 sustained abrasions that measured the following: the first abrasion was 2.8 centimeters (cm) x 2 cm, the second abrasion was 3.5 cm x 1.3 cm and the third abrasion was 1.2 cm x 0.6 cm. The abrasions were cleansed with normal saline, triple antibiotic ointment was applied and the area was wrapped with conforming gauze. Neurological checks were started.</p> <p>-On 1-26-21 it was noted Tenant #2's family was informed Tenant #2 was having a lot of lower back pain (family said was it normal for him). Tenant #2 also had small bruises on both of his sides and skin tears on his right elbow. Tenant #2 was able to walk but he was in pain.</p> <p>-On 1-29-21 it was noted Tenant #2 was unable to lay down or stand up due to severe pain from a fall two days earlier. Tenant #2 screamed in extreme pain with any movement or touch by staff. Tenant #2 had voided on himself, which was not normal for him and staff was not able to change him due to pain with any movement or touch. Tenant #2 voiced complaints of pain in his chest, back and bilateral upper extremities. Tenant #2 was sent to the emergency room (ER),</p>	A 140		

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A 140	<p>Continued From page 3</p> <p>-On 1-29-21 it was noted Tenant #2 returned from the ER, rib and spine x-rays were negative for fractures and a new order was received for lidocaine patches for 10 days, on in the morning and off at night.</p> <p>-On 1-29-21 it was noted Tenant #2's family continued to be concerned about Tenant #1's pain and a new order was received for a x-ray of the right hip.</p> <p>-On 2-1-21 it was noted new orders were received including: hydrocodone 5/325 milligram (mg), four times per day for 14 days, hydrocodone 5/325 mg, every eight hours as needed, lidocaine patch 4% patch to the right rib, on in the morning and off at night for 14 days and Senna S, daily for 14 days.</p> <p>-On 2-1-21 it was noted a new order was received for a x-ray of the left hip.</p> <p>-On 2-3-21 (late entry) it was noted Tenant #2 was found on the floor. He complained of head, neck and back pain. Neurological checks and vitals checks were started.</p> <p>Further record review revealed the service plan dated 2-1-21 was updated and reflected Tenant #2 had a fall on 1-26-21 with injuries and a fall on 2-2-21 with no injuries. The service plan also reflected the new medication orders as reflected above. The service plan was updated as needed with significant change, however, the evaluations were not completed with a significant change of condition.</p> <p>3. An interview on 3-23-21 at approximately 2:10 p.m. with the Resident Services Director and</p>	A 140		

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A 140	Continued From page 4 Navigator confirmed the above finding.	A 140		
A 635	<p>481-69.32(2) Life Safety - Emergency Policies / Structure</p> <p>69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to have an operating door alarm system connected to each exit door in a dedicated dementia specific assisted living program. This pertained to 1 of 1 tenant who left the Program without staff knowledge (Tenant #1). It potentially affected all tenants (census of 10). Findings follow:</p> <ol style="list-style-type: none"> <li>Record review on 3-23-21 of Tenant #1's file revealed no diagnoses were found in Tenant #1's file. Tenant #1 was staged at a three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline.</li> <li>When observed on 3-23-21 at approximately 5:35 p.m. Tenant #1 had left the dining room after the evening meal and was observed walking down the hallway towards his apartment. At approximately 5:38 p.m. Tenant #1 returned to the hallway and was wearing a hat and jacket. At approximately 5:45 p.m. Tenant #1 walked past the monitor in the hallway, wearing a hat and jacket (had an umbrella in his hand) and made a comment about looking for an open door.</li> <li>Continued record review revealed an Incident/Accident Report dated 10-31-20</li> </ol>	A 635		

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A 635	<p>Continued From page 5</p> <p>indicated a nurse from the health center was notified at approximately 6:45 p.m. that Tenant #1 was not in his apartment. A staff from the attached health center was sent to help locate Tenant #1. At approximately 7:00 p.m. the nurse was notified Tenant #1 was found at a nearby pharmacy. An electronic wandering monitoring device was placed on him and 15 minute checks were initiated. There were no injuries noted.</p> <p>4. An interview on 3-24-21 at 3:02 p.m. with the Resident Services Director and Navigator indicated the Resident Services Director was notified approximately between 6:00 p.m. to 7:00 p.m. that Tenant #1 was had left the unit. Staff B had found him and Tenant #1 said had left to get a package of gum. Tenant #1 was dressed appropriately, had a flashlight and did not sustain any injuries. The Resident Services Director drove to the Program and talked with Tenant #1 and his spouse about safety awareness. Five to six large nail clippers were removed from the apartment. It was determined he watched staff gather dishes in the kitchen and went around the corner (not visible) and took the elevator to the lower level. An electronic wandering monitoring device was placed back on Tenant #1 and 15 minute checks were initiated. She checked all with the doors and all functioned if the electronic wandering monitoring device was on. It was determined the system in place worked if the electronic wandering monitoring device was on but it did not work since Tenant #1 had cut his off. A keypad was placed to call the elevator.</p> <p>When interviewed on 3-23-21 at 3:00 p.m. Staff A she was on break and was training a staff (when the incident occurred with Tenant #1). When they returned from break Tenant #1 was gone. Tenant #1 had a tendency to go to a pharmacy, they got</p>	A 635		

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A 635	<p>Continued From page 6</p> <p>in a car and went to look for him. A staff from the health center found Tenant #1 up the street. Staff A said Tenant #1 had exit seeking behavior. He put on his coat and hat and would say he needed to go the bank or drug store.</p> <p>When interviewed on 3-24-21 at 11:00 a.m. Staff B said he worked primarily in the health center. He was told Tenant #1 was missing and went to look for him, including in the parking garage. He got his car keys and went towards 1st Avenue. He went to a pharmacy and asked someone outside of the store if he had seen him and he had. Staff B looked around and did not see Tenant #1. He was returning to his car and he saw Tenant #1 crossing to the other side of 1st Avenue near a gas station (walking diagonally). There were cars coming but he was not in immediate danger. Staff B ran across the street to get to him. Tenant #1 said he was trying to get gum. Tenant #1 was dressed appropriately for the weather, he had a hat and coat on. He had a flashlight but no wallet. Tenant #1 was agreeable to return to the building with Staff B and had no injuries. It was approximately 7:00 p.m. when he returned and Staff B took him to the unit. Staff B said it was dark outside and it was chilly; however, the temperature was not bad.</p> <p>5. A Program document indicated Tenant #1's physician was notified on 11-2-20 that Tenant #1 had cut off his electronic wandering monitoring device and walked off campus to a pharmacy. He was alert, unharmed, dressed appropriately and returned to the building with staff. Upon his return a new electronic wandering monitoring device was placed on him and discussion regarding safety occurred. Nail clippers were removed and 15 minute checks were initiated.</p>	A 635		

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A 635	<p>Continued From page 7</p> <p>An invoice from an alarm company indicated on 11-4-20 a keypad and "2 PAM relays" were installed to the elevator on first floor in the memory care unit.</p> <p>6. When observed on 3-23-21 at 5:32 p.m. the elevator nearest the kitchen area in the unit was observed. The elevator opened from two sides, one door opened to the hallway and one door opened to the kitchen. The hallway side of the elevator had a keypad that required a key code to put in to call for the elevator. Per interviews and record review this was the keypad that was installed on 11-4-20, after Tenant #1's incident on 10-31-20. The kitchen side of the elevator did not have a key pad.</p> <p>When observed on 3-23-21, Tenant #1's path traveled from the building to the pharmacy was not witnessed; however, possible terrain Tenant #1 could have traveled included: parking lots, city sidewalks and city streets. The street where Tenant #1 was located was 1st Avenue. It was a four lane major thoroughfare (with turn lanes) with a posted speed limit of 35 miles per hour (mph). There was construction near the area with a reduced speed limit. The distance by vehicle from the building to the pharmacy was approximately 0.8 of a mile.</p> <p>Weather conditions, provided by the State Climatologist, on 10-31-20 at approximately 6:00 p.m. and 8:00 p.m. (a 7:00 p.m. report was not available) were as follows: temperature was 54 degrees at 6:00 p.m. and 56 degrees at 8:00 p.m., relative humidity was 56% , winds were from the west at 13 mph at 6:00 p.m. and from the west north west at 21 mph at 8:00 p.m. There was no cloud cover and no wind chill.</p>	A 635		

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A 635	<p>Continued From page 8</p> <p>In summary, Tenant #1 left the dedicated dementia specific assisted living program without staff knowledge on 10-31-20. He was found approximately 0.8 of a mile away from the Program. Tenant #1 returned to the building with health center staff and he had no injuries. Tenant #1 had removed his electronic wandering monitoring device and exited the building via the elevator and parking garage. At the time of incident the elevator could be called for service if the tenant was not wearing an electronic wandering monitoring device. After Tenant #1's incident, a keypad was installed to call the elevator for service. The keypad installed required the code to be entered in the keypad to call the elevator on the hallway side of the elevator. There was no keypad on the kitchen side of the elevator. At the time of the incident with Tenant #1, the Program did not have all an operating door alarm system connected to each exit door.</p>	A 635		

Cottage Grove Place Compliant #94412, Incident Report #94539-I and onsite infection control survey

Plan of Correction from 3/16/21 to 3/25/21.

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

#### **A140 Evaluation of Tenant:**

**69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by professional, or licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change.**

Tenant #1 was evaluated the evening of October 31, 2020, with the initial incident and was unharmed.

Assisted Living designee reviewed all service plans in the Assisted Living program for accuracy on 3/15/21. Residents will be evaluated per guidelines unless a significant change has occurred. Behaviors are considered significant changes and will be added to the service plan and will be signed by responsible parties. Staff will continue to monitor behaviors and these changes will be noted as significant on the Condition Communication tool located on each floor of Assisted Living. Chart audits will occur over the next 30 days for compliance.

Tenant #1 had service plan adjusted on 11/5/20 after his behaviors on 10/31/20 based off the initial evaluation upon return to the unit. Education was provided to staff on April 4, 2021, regarding the Staff Communications Report that was developed to signify a significant changes, abnormal incident, or health change that will trigger an evaluations per regulations and a review of service plan for that change.

Tenant #2 had a fall on 1/29/21 with no fractures and an order for a lidocaine patch for 10 days. On 2/3/21 Tenant #2 was found on the floor complaining of back, head, and neck pain. Neurological checks and vitals were completed. The Service Plan was updated with a significant changes due to these occurrences.

Education was provided to staff on April 4, 2021, regarding the Staff Communications Report that was developed to signify a significant changes, abnormal incident, or health change that will trigger an evaluations per regulations and a review of service plan for that change.

The program has a spreadsheet to track all assessments, service plan changes and evaluations along with due dates. This tracking tool will be monitored by the Resident Services Director, Navigator, and Assisted Living Nurse. Weekly meetings occur with

Resident Services Director, Navigator, and the Assisted Living Nurse evaluate changes in all residents to discuss significant changes, evaluations, and service plan updates.

On March 15, 2021, all residents were reviewed for evaluations due, significant changes, and or behaviors. Updates to all residents were completed.

**Structure/Life Safety – A635:**

**69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.**

Tenant #1 exited the community on 10/31/20 after cutting his wander guard off and exiting through the #2 elevator. On 11/4/20 the program installed a coded keypad to that will not allow it to open for use without knowing the proper code. Elevator #2 is a two-sided elevator, allowing access behind a locked coded entry door for staff to access the kitchen for the program. A coded keypad will be installed on the kitchen side of the elevator on July 9th, 2021, or sooner pending Hawkeye Communication acquiring the proper device after review of wiring located near the elevator on Tuesday, July 6<sup>th</sup>, 2021.