

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: 7095	Fine Amount reduced by 35% to \$325.00 on February 12, 2020 pursuant to Iowa Code Section 135C.43A	Date: January 30, 2020
Facility Name: Kingston Hill	Survey Dates: December 10, 11, 12, 2019	
Facility Address/City/State/Zip 202 12 th St. SW Cedar Rapids, IA 52405	Initial Survey	
Rule or Code Section	Nature of Violation	Class Fine Amount Correction date

57.7(5)b.	481—57.7(135C) General requirements. 57.7(5) The licensee shall: <i>b.</i> Be responsible for compliance with all applicable laws and with the rules of the department. (I,II, III) Based on interview and record review the facility failed to comply with requirements related to notifications to the Department found in Iowa Administrative Code 481 - Chapter 50. Findings include: A review of incident reports on 12/10/19 revealed the facility failed to notify the Department of a major injury resulting in admission to a higher level of care for treatment as required by Iowa Administrative Code rule 50.7(1)a(2). The Administrator confirmed this finding. See deficiency under 50.7(1)a(2) for details.	II	\$500.00	Upon Receipt
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Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

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50.7(1) a (2)	<p>481—50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III):</p> <p>50.7(1) Of any accident causing major injury. a. "Major injury shall be defined as any injury which: (2) Requires admission to a higher level of care for treatment, other than for observation</p> <p>Based on interview and record review the facility failed to report to the Department of Inspections and Appeals an incident that caused a major injury leading to admission to a higher level of care for treatment (Resident C3) Findings include:</p> <p>A review of incident reports on 12/10/19 revealed Resident C3 had a choking incident that required the Heimlich maneuver by the Administrator on 8/25/19. Resident C3 was subsequently sent to the emergency room and was hospitalized for treatment.</p>			
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	<p>Resident C3 had a diagnosis of schizoaffective disorder. Resident C3 was independent in eating meals. Facility staff including the Administrator were present and eating in the small dining room during the choking incident on 8/25/19. Immediate action was taken by staff when Resident C3 was observed having difficulties.</p> <p>On 12/11/19 at 11:15 AM, the Administrator confirmed the Department was not notified of Resident C3's choking incident on 8/25/19.</p> <p>FACILITY RESPONSE:</p>			
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