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
	S0286	A. BUILDING: _____ B. WING _____	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRVING POINT	910 7TH STREET SE CEDAR RAPIDS, IA 52401

(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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 53 Number of tenants with cognitive disorder: 0 TOTAL census of Assisted Living Program: 53 The investigation of Complaint #80326-C resulted in regulatory insufficiencies.	A 000	See attached POC 3/21/19	
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow the policy and procedure regarding the completion of incident reports. This pertained to 2 of 2 discharged tenants reviewed (Tenants #1 and #2). Findings follow:	A 003		

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A 003	Continued From page 1 1. Record review of Tenant #1's file revealed an incident report dated 7-18-18 at 7:45 a.m. reflected staff found Tenant #1 on the floor next to her bed. Tenant #1 said she slid out of bed at 2:00 a.m. and could not get up. Tenant #1's pendant was hanging on the arm of the wheelchair. The incident report indicated Tenant #1 was taken to the hospital via ambulance and returned with no new orders or injuries. Staff C and D were listed on the incident report as witnesses. Continued record review revealed a Patient Communication Note dated 7-18-18 reflected at 7:50 a.m. staff notified a nurse that Tenant #1 had slid out of bed at approximately 2:30 a.m. Tenant #1 was incontinent of urine and stool and was laying in her own emesis. Tenant #1 was wedged between the night stand and bed. Two staff assisted her up and into the shower. A nurse assessed her and noted bruises on the right shoulder and a baseball size bruise on the coccyx. Tenant #1 complained of a sore hip. Tenant #1 was encouraged to go to the emergency room (ER). The area ambulance was contacted to transport to the ER; however, Tenant #1 did not want to go to the ER due to cost of transport. The doctor was notified of the fall. Further record review revealed the incident report dated 7-18-18 lacked detail of the description of the incident including: Tenant #1 was incontinent of urine and stool and had an emesis, Tenant #1's positioning between night stand and bed, vital signs and the refusal to go to the ER. The incident report was not complete and lacked information including: type of injury, physician notification, family/emergency contact notified and if first aid was administered. Staff C completed the report and there was no staff	A 003		

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A 003	Continued From page 2 witness statements completed. Continued record review of Tenant #1's file revealed A Transfer to Inpatient Facility form indicated a nurse was present for an assessment and Tenant #1 slid from her recliner to the floor and exhibited signs and symptoms of a cerebral vascular accident, including disorientation and slurred speech. Tenant #1 was admitted to the hospital. Tenant #1 transferred to a skilled nursing facility for therapies and was unable to return to the Program. The date of the occurrence could not be determined from the form; however, narrative documentation indicated on 9-3-18 that Tenant #1 was admitted to the hospital for a minor stroke. When interviewed on 1-30-19 at 3:25 p.m. the Nurse revealed an incident report was not found for the incident noted above for Tenant #1. 2. Record review of Tenant #2's file revealed an incident report dated 7-28-18 at 8:30 a.m. indicated Tenant #2 fell in her bedroom while trying to put on pants. There were no injuries. The incident report lacked detail of the incident including: if Tenant #2 had used her personal emergency response pendant, location of the assistive device as applicable and positioning of the tenant when found. The incident report was not complete and lacked information including: physician notification, family/emergency contact notified and if first aid was administered. Continued record review of Tenant #2's file revealed an incident report dated 9-17-18 at 6:00 a.m. reflected at 5:35 a.m. Staff A requested Staff B (a registered nurse) come to Tenant #2's apartment. Tenant #2 was found sitting on the	A 003		

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A 003	Continued From page 3 floor in her bedroom. Staff A sat Tenant #2 up when she found her laying on the floor. Tenant #2 reported after 9:00 p.m. as she picked her clothes, she turned, lost her balance and fell. Tenant #2 complained of right arm and right thigh pain. Tenant #2 was taken to the hospital, via ambulance and had a diagnosis of femur fracture. Staff A was listed as a witness and Staff B completed the incident report. Further record review revealed an Iowa Medicaid Critical Incident Report indicated Tenant #2 sustained a right shoulder fracture related to the incident. When interviewed on 1-29-19 at 1:22 p.m. Staff B revealed she was notified by Staff A to go to Tenant #2's apartment. Tenant #2 was found laying on the floor in her bedroom on her back. She was assisted to sit up and then requested to lay back down as she felt lightheaded. Staff A moved Tenant #2's walker and removed her pendant before Staff B responded to Tenant #2's apartment. Tenant #2 reported after staff left her apartment between 9:00 p.m. and 9:15 p.m. (the prior night) she stood in her closet in the bedroom, turned and lost her balance. Tenant #2 reported she pushed her pendant and the button broke and she kept pushing the pendant. Tenant #2 received no services or cares after bedtime medications until the morning medications. Tenant #2 complained of pain in the right hip/thigh and right arm. Vital signs were taken, an ambulance was called and family was notified. Tenant #2 had an upper right arm fracture that did not require surgical repair. Continued record review revealed a witness statement for Staff A was not completed. The incident report lacked detail of the incident	A 003		

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A 003	Continued From page 4 including: if Tenant #2 had used her personal emergency response pendant, vital signs, location of the pendant when Tenant #2 was found, location of the assistive device, positioning of the tenant when found and if any statement was made from Tenant #2 regarding the incident. Further record review revealed the Program's policy and procedure for Incident Reporting reflected the policy was to ensure appropriate documentation was completed and appropriate notifications were made. All accidents and incidents in the building (or on property) that affected tenants would be documented on the incident report form. The incident report form would include: detail of the incident and statements from any witnesses. The report would be prepared and signed by the person in charge at time of the incident. The completed forms would be maintained on-site for three years.	A 003		
A 096	481-69.27(1)c Nurse Review 481-69.27(231C) Nurse review. 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 or a licensed practical nurse via nurse delegation: 69.27(1)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;	A 096		

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A 096	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse reviews as needed. This pertained to 2 of 2 discharged tenants reviewed (Tenants #1 and #2). Findings follow: 1. Record review of Tenant #1's file revealed A Transfer to Inpatient Facility form indicated a nurse was present for an assessment and Tenant #1 slid from her recliner to the floor and exhibited signs and symptoms of a cerebral vascular accident, including disorientation and slurred speech. Tenant #1 was admitted to the hospital. Tenant #1 transferred to a skilled nursing facility for therapies and was unable to return to the Program. The date of the occurrence could not be determined from the form; however, narrative documentation indicated on 9-3-18 Tenant #1 was admitted to the hospital for a minor stroke. A nurse review was not completed related to incident noted above with Tenant #1 including the incident, transfer and subsequent discharge from the Program. 2. Record review of Tenant #2's file revealed an incident report dated 9-17-18 at 6:00 a.m. reflected at 5:35 a.m. Staff A requested Staff B (a registered nurse) come to Tenant #2's apartment. Tenant #2 was found sitting on the floor in her bedroom. Staff A had sat Tenant #2 up when she found her laying on the floor. Tenant #2 reported after 9:00 p.m. as she picked out her clothes, she	A 096		

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A 096	Continued From page 6 turned, lost her balance and fell. Tenant #2 complained of right arm and right thigh pain. Tenant #2 was taken to the hospital, via ambulance and had a diagnosis of femur fracture. Staff A was listed the employee involved in the incident. Staff A was listed as a witness and Staff B completed the incident report. Continued record review revealed an Iowa Medicaid Critical Incident Report indicated Tenant #2 sustained a right shoulder fracture related to the incident. When interviewed on 1-29-19 at 1:22 p.m. Staff B revealed she was notified by Staff A to go to Tenant #2's apartment. Tenant #2 was found laying on the floor in her bedroom on her back. She was assisted to sit up and then requested to lay back down as she felt lightheaded. Staff A moved Tenant #2's walker and removed her pendant before Staff B responded to Tenant #2's apartment. Tenant #2 reported after staff left her apartment between 9:00 p.m. and 9:15 p.m. (the prior night) she was standing in her closet in the bedroom and turned and lost her balance. Tenant #2 reported she had pushed her pendant and the button broke. She kept pushing the pendant. Tenant #2 received no services or cares after bedtime medications until the morning medications. Tenant #2 complained of pain in the right hip/thigh and right arm. Vital signs were taken, an ambulance was called and family was notified. Tenant #2 had an upper right arm fracture that did not require surgical repair. Further record review of Tenant #2's file revealed discharged from the Program on 9-18-18. A nurse review was not completed related to incident noted above with Tenant #2 including the incident, transfer, the injury sustained and	A 096		

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A 096	Continued From page 7 subsequent discharge from the Program. 3. When interviewed on 1-30-19 at 3:25 p.m. the Nurse confirmed there were no other documents for a nurse review for the tenants indicated above for the time period requested.	A 096		

✓ 4/22/19

OK
4/19/19

February 27, 2019

Department of Inspections and Appeals
Attn: Catie Campbell
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Kellen:

On behalf of Irving Point in Cedar Rapids, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Monitoring Report dated February 21, 2019. 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 conclusions set forth in the statement of insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of state law.

Program Policies and Procedures

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenant #1 and #2 no longer resides at Irving Point.

2. What measures will be taken to ensure the problem does not recur.
    - The Administrator and RN will be re-educated on regulatory requirements and Irving Point Policies and procedures related to completion of incident reports.

3. How the Program plans to monitor performance to ensure compliance.
    - The Administrator, RN, and/or Designee will audit tenant records and incident reports at least two times per year for compliance.

4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be corrected by March 21, 2019.

Nurse Review

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Tenants #1 and #2 no longer resides at Irving Point.

2. What measures will be taken to ensure the problem does not recur.
    - The RN will be re-educated on regulatory requirements for Nurse Review.

3. How the Program plans to monitor performance to ensure compliance.
    - The Administrator, RN, or Designee will audit tenant files at least two times per year to ensure compliance.

4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be corrected by March 21, 2019.

If you have any questions regarding this plan of correction, please feel free to contact me at 319-294-5007. Thank you.

Sincerely,

Tina Willmsen

Tina Willmsen
Administrator