2/13/20

PRINTED: 01/14/2020
FORM APPROVED

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
	IAK0170	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSTON HILL	202 12TH STREET SW CEDAR RAPIDS, IA 52405

(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
R 000	Initial Comments The following deficiencies were cited during the initial survey conducted to determine compliance with licensing rules for a Residential Care Facility.	R 000	see attached Plan of Correction	
R 266	481-57.7(5)b General Requirements 481-57.7(135C) General requirements. 57.7(5) The licensee shall: b. Be responsible for compliance with all applicable laws and with the rules of the department. (I, II, III) This REQUIREMENT is not met as evidenced by: 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.	R 266		
R 828	481-57.22(3) Orientation and Service Plan 57.22(3) Service plan. Within 30 days of admission, the administrator or the	R 828		

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
	IAK0170	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSTON HILL	202 12TH STREET SW CEDAR RAPIDS, IA 52405

(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
R 828	Continued From page 1 administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure 30 day service plans were completed for 2 of 3 residents reviewed (Resident #1, Resident #3). Findings include: Resident #1 was admitted to the facility on 9/12/19. An initial service plan was created and implemented upon admit. As of 12/10/19, no 30 day service plan had been implemented for Resident #1. Resident #3 was admitted to the facility on 8/27/19. An initial service plan was created and implemented upon admit. As of 12/10/19, no 30 day service plan had been implemented for	R 828		

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
	IAK0170	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSTON HILL	202 12TH STREET SW CEDAR RAPIDS, IA 52405

(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
R 828	Continued From page 2 Resident #1. On 12/10/19 at 1:05 PM, the Administrator confirmed they had not completed 30 service plans on the residents reviewed.	R 828		
C 139	50.7(1)a(2) Additional notification 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: 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; This REQUIREMENT is not met as evidenced by: 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: 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.	C 139		

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
	IAK0170	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSTON HILL	202 12TH STREET SW CEDAR RAPIDS, IA 52405

(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
C 139	Continued From page 3 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. 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.	C 139		

DIA Survey completed 12/12/2019 Plan of Correction

Orientation and Service Plan 481-57.22

The Director of Social Services, Social Worker, and Director of Nursing will be trained on the policy and procedure *Individual Service Plan* as well as the applicable Iowa Administrative Code sections. This training will be completed by 2/14/2020.

The Director of Social Services will maintain a calendar of when the 30 day Service Plan review is due and coordinate scheduling of same. The Director of Social Services is responsible to ensure this requirement is met and will review this monthly. This is in effect immediately.

Incident Reporting 481-50.7, 481-57.17

The Director of Social Services, Social Worker, Director of Nursing, and Activity Coordinator will be trained on the policy *Investigation and Reporting of Accidents or Incidents* as well as the applicable Iowa Administrative Code sections. The Director of Nursing is responsible to ensure incidents are reported to the Director within reporting requirements. This training will be completed by 2/14/2020.

All staff will be trained on the policy *Investigation and Reporting of Accidents or Incidents* by 3/6/2020.

Aaron Pauls

Aaron Pauls, Administrator

2/6/2020

2/13/20

2/13/20