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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP286	A. BUILDING _____ B. WING _____	02/13/2023

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: 56 Number of tenants with cognitive disorder: 0 TOTAL census of Assisted Living Program: 56 The following regulatory insufficiencies were cited during the investigation of Complaints #106822-C and #107345-C:	A 000	See Attached POC 6/3/23	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to implement established policy and procedure related to transfers (discharge). This pertained to 1 of 1 tenant reviewed that was issued a transfer notice (Tenant #2). Findings follow: 1. Record review on 2/9/23 and 2/13/23 revealed Tenant #2 signed a Lease Agreement on 9/29/20. Tenant #2 signed a Smoke Free Lease Addendum on 10/25/21, which indicated the Program had a no smoking policy. The addendum included rules and conditions which were incorporated into the Lease Agreement. The agreement indicated a violation of the policy would be a "material breach of the Lease and is grounds for termination of the Lease by the Lessor." Continued record review revealed a A Notice of Material Noncompliance with Rental Agreement,	A 150		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 150	Continued From Page 1 And Notice of Intention To Terminate Rental Agreement dated 11/3/22 was issued to Tenant #2. It was noted during a replacement of filters in apartments Tenant #2's filter showed signs of cigarette smoke. The notice indicated if the violations were not corrected within seven days after the date of the notice, the rental agreement would terminate 30 days after the date of service of the notice. If the same violation occurred again within six months, the rental agreement would be terminated in seven days with written notice. Further record review revealed a Notice of Repeated Noncompliance With Rental Agreement, And Notice of Termination of Rental Agreement dated 2/6/23 was issued to Tenant #2. On 1/30/23 the Program followed up regarding a concern that Tenant #2's apartment smelled like smoke and the filter showed signs of smoke. A copy of the no smoking policy and pictures of the filter were provided. Tenant #2 had a similar violation dated 11/3/22 and the notice indicated the rental agreement would be terminated in seven days. A United States Postal Service Certified Mail Receipt was provided addressed to the Office of the State Long Term Care (LTC) Ombudsman dated 2/6/23. Tenant #2 refused to sign the Acknowledgement of Delivery notice. Continued record review revealed a Program document dated 2/10/23 indicated Tenant #2 requested an appeal hearing to remain at the Program. The appeal hearing was held on 2/9/23 at 2:30 p.m. with Tenant #2, a family member (power of attorney), LTC Ombudsman, Tenant #2's case manager and the Administrator. The document indicated the appeal was denied but the Program provided more time for Tenant #2 to find alternative placement. The letter indicated Tenant	A 150		

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A 150	Continued From Page 2 #2 had until 3/13/23 to find alternative placement. The rental agreement would terminate on 2/17/23; however, the Program would not file a "petition seeking eviction until March 13, 2023." 2. Record review on 2/9/23 and 2/13/23 of the Program's policy and procedure related to Transfers indicated the nurse would notify the tenant's physician of the planned transfer. 3. Record review on 2/9/23 and 2/13/23 of Tenant #2's file revealed the file lacked documentation of Tenant #2's primary care provider/physician notification regarding Tenant #2's transfer. 4. When interviewed on 2/13/23 at 11:51 a.m. and 12:50 p.m. the Administrator said approximately October, Tenant #2's family called and said Tenant #2 was smoking in her apartment. Tenant #2's filter was checked and she received the first warning and was given time to correct within seven days. In late January staff smelled smoke, her filter was checked and it was yellow. A repeated non-compliance notice was given to her dated 2/3/23, then it was voided and given again on 2/6/23 with pictures and the policy. Tenant #2 requested a hearing and it was held on 2/9/23. Tenant #2 was given an additional 30 days to find placement and the transfer date was extended to 3/13/23. The Program did not have a document for a power of attorney for Tenant #2. The LTC Ombudsman was sent the letter (related to appeal) on 2/10/23. The Administrator confirmed the Nurse had not contacted Tenant #2's physician regarding the transfer.	A 150		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted	A 350		

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A 350	Continued From Page 3 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. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to develop service plans based on evaluations. This pertained to 3 of 5 tenants reviewed (Tenants #1, #4 and #5). Findings follow: 1. Record review on 2/9/23 and 2/13/23 of Tenant #1's file revealed a service plan was updated on 6/6/22 (30 day review). The service plan was not based on evaluations as the evaluations were not completed. 2. Record review on 2/9/23 and 2/13/23 of Tenant #4's file revealed service plan dated updated on 1/28/23 (annual). The service plan was not based on evaluations as evaluations were not completed. 3. Record review on 2/9/23 and 2/13/22 of Tenant #5's file revealed a hospice document indicated Tenant #5 was admitted to hospice on 7/11/22. The service plan reflected a review date of 7/2022 and reflected hospice services started. The service plan update was not based on evaluations as evaluations were not completed. 4. When interviewed on 2/13/23 at 12:50 p.m. the Administrator confirmed all service plans and evaluations for the tenants listed above were provided.	A 350		

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A 455	Continued From Page 4	A 455		
A 455	481-69.28(3) Food Service 69.28(3) Menus shall be planned to provide the following percentage of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences based on the number of meals provided by the program: a. A minimum of 33? percent if the program provides one meal per day; b. A minimum of 66? percent if the program provides two meals per day; and c. One hundred percent if the program provides three meals per day. This Requirement is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure planned menus provided the recommended daily allowances for each meal. This potentially affected all tenants (census of 56). Findings follow: 1. When observed on 2/8/23 at 5:00 p.m. the evening meal was a Hawaiian slider, relish tray, and bread pudding. The slider was a small slider bun with a half to one slice of ham and a slice of cheese on a small roll. A starch/potato dish was not observed. The evening meal included a relish tray, which had two small celery pieces, two slices of cucumber, two small carrots with dip and a piece of bread pudding for dessert. A group of tenants who attended the small group meeting on 2/8/23 at 2:00 p.m. called the monitor to their table to look at the portion size of the sandwich. The tenants said there was a half slice of ham folded over and commented on the size of the sandwich. The portion of the meat was minimal, the size bun was a Hawaiian dinner roll, there was one slider served to each tenant and there was no separate	A 455		

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A 455	Continued From Page 5 starch dish observed. Record review of the February 2023 menu indicated the planned items for dinner on 2/8/23 were: Hawaiian sliders, relish tray with dip and bread pudding. Continued observation on 2/9/23 at 12:00 p.m. revealed the lunch meal was scalloped potatoes with ham, carrots and peas, fruit cocktail, and a brownie with ice cream. Staff B said she added the fruit cocktail as she needed a fruit. Record review of the February menu indicated the planned items for lunch on 2/8/23 were: scalloped potatoes and ham, a vegetable, and a brownie with ice cream. Continued record review revealed the menus provided by the Program did not provide serving size in terms of ounces per food group or dish served or nutritional information of the items served. 2. A tenant group meeting was held on 2/8/23 at 2:00 p.m. and the tenants said the portion size of the food was not sufficient. A comment was also made regarding portion sizes varying at times from tenant to tenant. They said tenants were involved with menu planning and that had not happened previously. The variety was not always sufficient but a comment was made that the tenants planned the menus. The tenants said second portions were not available when requested. The tenants also said the temperature of the hot foods, vegetables especially, needed improvement. 3. Record review of electronic mail (emails) from Tenant #4 to the Administrator indicated the following:	A 455		

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A 455	Continued From Page 6	A 455		

-On 1/11/23 Tenant #4 indicated there were times she had not received her meals delivered to her apartment. She was told by staff on the weekends that they did not make enough food and the apartments did not get anything (delivered meals). On 1/12/23 the Administrator responded to Tenant #4 and requested that she make her aware of the issue right away so it could be addressed and to let her know each time she had a problem.

-On 1/31/23 Tenant #4 indicated she called and ordered her meals to be delivered before 10:00 a.m. for both lunch and dinner. Tenant #4 indicated she did not receive the same meal that was served to the tenants in the dining room. She indicated she received the same meal from lunch except without a few items. Tenant #4 said she received dry chicken dressing and canned pears with three blueberries. Tenant #4 indicated she did not receive any protein that day. The Administrator responded on 2/1/23 and indicated she spoke with staff and the kitchen had run out of the scheduled meal. They used left overs from lunch.

3. When interviewed on 2/9/23 at 10:50 a.m. Staff A said the tenants did not receive enough food. She said there were complaints on a very regular basis, three to five times per week, regarding portion size or quality. She said the portion size was below average. She also said there were no alternatives available. She had received tenant complaints regarding insufficient food. She said Tenant #4, who had meals delivered, had complained about not getting a meal delivered to her on the weekends.

When interviewed on 2/9/23 at 11:44 a.m. Staff C said the tenants did not receive enough food related to the portion size. Staff C said she had

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A 455	Continued From Page 7 heard a few complaints about tenants still being hungry. When interviewed on 2/9/23 at 12:52 p.m. Staff F said sometimes the portion size could be bigger. When interviewed on 2/8/23 at 3:41 p.m. Staff B said the menu planning was a combination of the tenants at a meeting once per month and Staff B (primary cook). She said the tenants wrote down what they wanted to have for the month on a calendar document. She put it on a spreadsheet and arranged it for prep and budget. She said there was no nutritional information/components on the menus. She shared the menus with two staff, including the Owner. She said the portion size was small but the tenants seemed pleased. When interviewed on 2/9/23 at 2:56 p.m. the Registered Dietician said she was an independent contractor and she not received menus from the staff at Queen Bees, Inc. (dietary provider at Irving Point) since August 2021. They had previously sent menus for lunch and dinner and the tenants provided breakfast on their own. The menu was sent on a calendar, not a spreadsheet. She had a provided a spreadsheet with portion sizes of menu items. She had emailed staff at Queen Bees, Inc. in February 2022 and June 2022 regarding menus and received no response. She said a staff emailed her on 12/26/22 and asked if she had received menus, she told responded no on 1/3/23. On 2/9/23 (date of interview) she had received an email from staff regarding the menus. When interviewed on 2/13/23 at 11:51 a.m. the Administrator said she had received complaints about smaller portions at the tenant council meetings, she followed up with the Owner and it had improved in the last couple of months. She had received a complaint on Friday regarding	A 455		

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A 455	Continued From Page 8 portion size being too small. 4. Record review revealed monthly tenant weights were requested and could not be located at the time of the investigation. 5. When interviewed on 2/9/23 at 10:06 a.m. the Owner of Queen Bees, Inc. and Comfort Care said the menus had been going to a dietician for review, Staff B took it over and it had not been going over for review. She was not sure when the menus stopped going to the dietician for review.	A 455		
A 465	481-69.28(5) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This Requirement is not met as evidenced by: Based on observation, interview and record review the Program failed to provide an orientation on safe food handling for staff prior to handling food and annually. This pertained to 4 of 4 staff reviewed that prepared and/or served food (Staff A, B, D and E). Findings follow: 1. Observation on 2/8/23 at 11:55 a.m. revealed Staff A and Staff E served food from the serving counter to the tenants for the lunch meal. Staff D was in the kitchen and dished up the food prepared. Continued observation on 2/8/23 at 5:00 p.m. and 2/9/23 at 12:00 p.m. revealed Staff B prepared food for the meal and dished up the food	A 465		

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A 465	Continued From Page 9 prepared. On 2/9/23 at 12:00 p.m. Staff E served food from the serving counter to the tenants and delivered meals to tenant apartments. 2. Record review on 2/13/23 of staff food safety training documents revealed a Safe Food Handling Inservice document was signed by Staff B dated 1/21/22. Staff B did not have annual food safety and sanitation training completed. Staff A, D and E did not have any food safety and sanitation training completed. 3. When interviewed on 2/9/23 at approximately 4:00 p.m. and on 2/13/23 at 11:51 a.m. the Administrator confirmed no food safety and sanitation training was completed for Staff A, D and E.	A 465		

Irving POINT
AFFORDABLE ASSISTED LIVING

May 10, 2023

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

Dear Ms. Campbell:

On behalf of Irving Point in Cedar Rapids, Iowa, I respectfully submit our Plan of Correction for your approval. This response is specific to the report for the onsite visit between February 8 through February 13, 2023. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusion set forth in the statement of insufficiencies. The Plan of Correction is executed solely because it is required by the provisions of Iowa Law.

Policies and Procedures.

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.

   The licensed nurse will be re-educated on policies and procedures related to no smoking; specifically, the requirement to notify the physician regarding transfer.

   The licensed nurse will be re-educated on involuntary transfer protocol as identified per regulation.

2. Measures taken to ensure the problem does not recur.
   The Administrator and licensed nurse will review policy and procedure as it relates to such incidents in the future to ensure all aspects of the policy are followed.

3. How the Program plans to monitor performance to ensure compliance.

   The Administrator or Designee will review tenant files at least annually to confirm compliance.

4. The date by which the regulatory insufficiency will be corrected.
   This plan of correction will be completed on or before June 3, 2023.

Service Plans.

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.

910 7th Street S.E. ▪ Cedar Rapids, Iowa 52401
(319) 294-5007 ▪ (319) 337-2430 fax

The RN will update service plan for tenant #1 and #4. The service plan will be supported by a health, functional, and cognitive evaluation.
Tenant #5 no longer resides at Irving Point.

2. Measures taken to ensure the problem does not recur.
   The RN will be re-educated on regulatory requirement for service plan development.

3. How the Program plans to monitor performance to ensure compliance.

   The Administrator or Designee will review tenant files at least annually to confirm compliance.

4. The date by which the regulatory insufficiency will be corrected.
   This plan of correction will be completed on or before June 3, 2023.

Food Service.

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.

   The food service provider, Queen Bees, will provide menus to Irving Point to confirm the menu meets the required daily allowances as required per regulation.
   Staff will have appropriate training on safe food handling as required by regulation.

2. Measures taken to ensure the problem does not recur.
   The Owner of Queen Bees will be re-educated on regulatory requirements for meal service.
   The Owner of Queen Bees will be re-educated on regulatory requirements for safe food handling.
   The Owner of Queen Bees will provide Irving Point with copies of Safe Food Handling confirmation for employees.

3. How the Program plans to monitor performance to ensure compliance.

   The Administrator or Designee will monitor for compliance at least annually.

4. The date by which the regulatory insufficiency will be corrected.
   This plan of correction will be completed on or before June 3, 2023.

Contact me at 319-294-5007 with any questions. Thank you.

Sincerely,

Sally Page
Administrator