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 07/17/2024

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: 52 Number of tenants with cognitive disorder: 0 Total census of Assisted Living Program: 52 There were no regulatory insufficiencies cited related to Complaints #120815-C and #120816-C. The following regulatory insufficiencies were cited during the investigation of Complaint #117352-C, Complaint #117780-C and the recertification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000		
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 follow its policies and procedures related to head injuries, incident reports and nutrition. This pertained to 3 of 5 current tenants (Tenants #1, #2, and #4) and 1 of 2 discharged tenants (Tenant C1) reviewed. Findings follow: 1. Review of Tenant #1's file on 7/16/24 and 7/17/24 revealed an After Visit Summary reflecting Tenant #1 was hospitalized from	A 150	The Plan of Correction is attached.	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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A 150	Continued From page 1	A 150		

6/23/24 to 7/4/24 for aspiration pneumonia. Diet instructions included soft and bite size foods with moderately thick liquids. Pills were to be administered one at a time in pudding or applesauce and no straws were to be used. Thickened liquids, moderately thick, could be drunk from a cup or eaten with a spoon.

When interviewed on 7/16/24 at 4:59 p.m. the Nurse said Tenant #1 had thickened liquids (nectar). She said staff assisted him. The Thick-it was kept in the kitchen in his apartment. He could do it himself with staff assistance. There was not a dietician involved with Comfort Care (home care agency/service provider). The home care nurse put information in the staff communication book for staff related to the thickened liquids.

On 7/16/24 at 3:32 p.m. Staff C said Tenant #1 had thickened liquids. Staff helped him measure and pour into the bottle.

When interviewed on 7/17/24 at 2:00 p.m. Staff D said Tenant #1 had thickened liquids.

Review of the Nutrition Program policy on 7/8/24 indicated therapeutic diets were not offered at Irving Point. Tenants who required a therapeutic diet could request assistance from Comfort Care Medicare Inc. in their apartment. It was not guaranteed Comfort Care Medicare Inc. would be able to accommodate the diet. It would be evaluated on a case by case basis. If a therapeutic diet was assisted by Comfort Care Medicare Inc. a licensed dietician would write and approve the therapeutic menu, would use the Iowa Simplified Diet Manual and would review with staff the appropriate procedures for preparation and service of the food. The

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A 150	Continued From page 2	A 150		

therapeutic diet would be prescribed by a physician.

The staff communication book indicated on 7/5/24 staff was to assist with helping Tenant #1 make thickened liquids. Tenant #1 was not to use a straw, liquid was to be thick enough to drink from a cup or spoon, medications were to be given one at a time in applesauce or pudding.

The Program did not follow the policy and procedure related to nutrition and therapeutic diets related to Tenant #1. Staff were assisting Tenant #1 with his thickened liquids and there was no dietician involvement or documented staff training to review preparation of the beverages.

2. Review of Tenant #4's file on 7/16/24 revealed incident reports indicating the following:
- On 6/16/24 at 3:50 a.m. Tenant #4 tried to get up to go to the bathroom, lost her balance and fell. She had a lump on her head. It indicated she did not go to the hospital and vitals were not taken.
- On 6/21/24 at 3:15 a.m. Tenant #4 slipped out of her recliner and hit her head on the side table. The report indicated Tenant #4 was not taken to the hospital.
- On 6/21/24 at 3:25 p.m. Tenant #4 walked from the elevator, her right leg gave out, her walker wheel turned and she fell. She complained of left shoulder pain and she hit the left back side of her head. It indicated she refused to go to the hospital and refused to have her emergency contact person notified.
- On 7/13/24 at 3:55 p.m. Tenant #4 tried to open her laundry pod container, slipped and fell. She hit her head on the cupboard door. She had a bruise on her forehead. Staff encouraged Tenant #4 to go to the emergency department

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A 150	Continued From page 3 (ED) but she refused to go. It was noted Tenant #4 was on two hour checks. The staff communication book indicated on 6/21/24 Tenant #4 fell and hit her head and she had two hour checks for 24 hours. It also indicated on 7/13/24 Tenant #4 fell and hit her head. She was on two hour checks. The Program's Head Injury policy indicated if a tenant fell and struck their head on a solid surface the nurse would be notified immediately. If there was any reported head trauma the tenant would be advised to be evaluated by a physician. If the tenant refused medical care, the nurse would implement two hour checks for 24 hours and any change in condition would be reported immediately to the nurse. When interviewed on 7/16/24 at 4:59 p.m. the Nurse said with any fall the staff communicated it to the nurse and the incident reports were scanned. The tenant was notified they needed to go to the ED. If they refused to go then two hour checks were started for 24 hours. The tenant was checked every 2 hours to make sure they were still doing okay. There was not a special documentation form, but the checks should be written in the staff communication book. Regarding Tenant #4, she had fallen, hit her head and refused to go the ED. The Head Injury policy was not followed as evidenced by: - The incident report on 6/16/24 at 3:50 a.m. documented the tenant did not go to the hospital post fall/hitting head, but did not specify if she refused to go and did not indicate if 2 hours checks were to be completed for 24 hours. - The incident report on 6/21/24 at 3:15 a.m.	A 150		

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documented the tenant was not taken to the hospital after hitting head but did not specify if she refused to go and did not indicate if 2 hours checks were to be completed for 24 hours.
- The incident report on 6/21/24 at 3:25 p.m. noted Tenant #4 refused to go the ED. The incident report did not indicate if two hour checks would be completed for 24 hours.
- The 7/13/24 incident report referenced two hour checks post fall. Communication notes indicated checks would be completed for the 7/13/24 incident. The checks referenced were not documented.

3. When interviewed on 7/17/24 at 2:00 p.m. Staff D said Tenant #2 was missing her salt and pepper shakers about two months ago. She became aware of it from everyone talking about it.
Review of Tenant #2's file on 7/16/24 did not document any missing items. Review of incident reports did not reveal an incident report for the missing items, including the salt and pepper shakers. An email dated 7/17/24 at 4:08 p.m. from the Administrator indicated she did not locate any documentation related to Tenant #2's lost salt and pepper shakers. She confirmed an incident report was not completed.

Review of Tenant C1's file on 7/9/24 revealed incident reports related to falls dated 9/12/23 and 10/13/23. Review of the staff communication book indicated Tenant C1 fell on 10/14/23 and 10/19/23. The note indicated on 10/19/23, Tenant C1 fell in the kitchen and her right ankle was hurt. She was unable to walk and went to the hospital. Incident reports were not found related to the falls on 10/14/23 and 10/19/23.

The Program's policy and procedure related to

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A 150	Continued From page 5 Incident Reporting indicated all accidents or unusual occurrences that affected tenants would be documented on an incident report form. The Program failed to follow the policy and procedure related to the completion of incident reports for Tenant #2 and Tenant C1. 4. When interviewed on 7/17/24 at 3:04 p.m. the Administrator confirmed all incident reports were provided for the tenants reviewed.	A 150		
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 a cognitive evaluation within 30 days of occupancy. This pertained to 1 of 1 discharged tenants reviewed admitted in 2023 (Tenant C2). 1. Review of Tenant C2's file on 7/15/24 revealed Tenant C2 was first admitted on 7/27/23. A Health and Functional Assessment was completed on 7/27/23 and 8/28/23. A cognitive evaluation was completed dated 7/27/23; however, a cognitive evaluation was not completed within 30 days of taking occupancy.	A 140		

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A 140	Continued From page 6 2. When interviewed on 7/16/24 at 3:04 p.m. the Administrator confirmed all evaluations were provided for the tenants reviewed.	A 140		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. 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. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations either annually or as needed with significant change. This pertained to 2 of 5 current tenants (Tenant #2 and Tenant #4) and 1 of 2 discharged tenants (Tenant C2) reviewed. Findings follow: 1. Review of Tenant #2's file on 7/15/24 to 7/17/24 revealed a Cognitive Ability Assessment dated 2/27/24. A service plan was also dated 2/27/24. Health and functional evaluations were completed on 5/23/24, approximately 3 months after the service plan was developed.	A 145		

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A 145	Continued From page 7 2. Review of Tenant #4's file on 7/15/24 to 7/17/24 revealed a fax was sent to the primary care provider (PCP) dated 3/7/24 which indicated Tenant #4's medication list was enclosed for review as Tenant #4 wanted the Program to start helping with her medications. Continued review revealed a Cognitive Ability Assessment was dated 3/5/24. A service plan, also dated 3/5/24, reflected Tenant #4 wanted to switch to a medication assist since she was dropping medications. Tenant #4 still completed her daily intramuscular injection. Health and functional evaluations were not completed as needed with the change to assistance with medications. Patient Communication Notes indicated the following: - On 6/21/24 it was noted Tenant #4's buttocks had a pinhole size open area on the left side of the coccyx and there was a small rough area on the opposite side. A clobetasol cream was applied and she was reminded to keep pressure off of the area. - On 6/21/24 it was noted Tenant #4 needed a barrier cream and not clobetasol for her buttocks. A verbal order was received to apply A & D ointment (without zinc), twice daily and as needed. Further record review revealed evaluations were not completed with Tenant #4's open area and treatment of the area. 3. Review of Tenant C2's file on 7/15/24 revealed health, functional and cognitive evaluations were completed on 11/16/23 post hospitalization and skilled nursing stay. The Health and Functional	A 145		

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A 145	Continued From page 8 Assessment indicated Tenant C2's skin was intact. Continued record review revealed hospital records indicated Tenant C2 was admitted on 11/22/23 and discharged on 12/6/23. She was discharged to a skilled nursing facility. Hospital problems included acute metabolic encephalopathy, acute cystitis with hematuria, sepsis with encephalopathy without septic shock and hypertensive emergency. The hospital records reflected a past history of type 2 diabetes mellitus with neurological complication and left foot amputation. During the hospitalization it was noted Tenant C2 had multiple scattered wounds on her right second through fourth toes and the distal end of the transmetatarsal amputation (TMA). The wound location was on the right foot and was present upon admission. The etiology indicated diabetic ulcers and trauma. The wounds included: - On the anterior 4th toe cluster, it measured 0.8 x 0.6 centimeter (cm), it was 100% dry brown, and it was unstageable - On the lateral 3rd toe, it measured 0.8 x 0.6 cm, it was an intact drying blood blister, and it was unstageable - On the anterior 2nd toe, it measured 0.3 x 0.2 cm, it was 100 % dry brown, and it was unstageable - On the posterior lateral heel, it measured 2.1 x 0.6 cm, it was 100% dry dark brown, hyperkeratotic skin, and it was unstageable. The wound location on the left distal TMA was present on admission and the etiology was noted as diabetic ulcer and trauma. The wounds included:	A 145		

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A 145	Continued From page 9 - On the 1st metatarsal (MT) area, it was 1.2 x 1.2 cm, it 100% dry brown and the edges were starting to lift, and it was unstageable - On the 3rd MT area cluster, it was 1.4 x 0.9 cm, the epidermis was intact with a dark red under, and it was unstageable Review of the tenant's file revealed cognitive, health and functional evaluations were dated 11/16/23, however, the health and functional evaluation indicated Tenant C2's skin was intact on 11/16/23. Upon admission to the hospital on 11/22/23, Tenant C2 had multiple wounds on her right foot and her left TMA. The health evaluation completed did not reflect the skin issues as noted above. 4. When interviewed on 7/17/24 at 3:04 p.m. the Administrator confirmed all evaluations were provided for the tenants reviewed.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 3 of 5 current	A 290		

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A 290	Continued From page 10	A 290		

tenants (Tenants #1, #4, and #5) and 2 of 2 discharged tenants (Tenant C1 and Tenant C2) reviewed. Findings follow:

1. Review of Tenant #1's file on 7/16/24 and 7/17/24 revealed an After Visit Summary (AVS) indicating Tenant #1 was hospitalized from 6/6/24 to 6/10/24 for acute hypoxemic respiratory failure. A second AVS revealed Tenant #1 was hospitalized for aspiration pneumonia from 6/23/24 to 7/4/24.

Further review revealed nurse's notes were not completed when Tenant #1 left or returned from the hospital with the 6/6/24 to 6/10/24 hospitalization. Nurse's notes were also not completed when Tenant #1 left or returned from the hospital with the 6/23/24 to 7/4/24 hospitalization.

2. Review of Tenant #4's file on 7/16/24 revealed incident reports indicating she had falls on 4/3/24, 4/21/24, 5/17/24, 5/29/24, 6/16/24, twice on 6/21/24, 6/28/24, 6/29/24, 7/5/24 and 7/13/24. Nurse's notes were not completed with each fall.

3. Review of Tenant #5's file on 7/16/24 revealed an AVS indicating Tenant #5 was hospitalized from 6/2/24 to 6/4/24 for pneumothorax. A second AVS indicated Tenant #5 was hospitalized from 6/21/24 to 6/25/24 for acute and chronic respiratory failure with hypoxia; and a third AVS revealed hospitalization from 7/9/24 to 7/15/24 for chronic respiratory failure with hypoxia. Nurse's notes were not completed when Tenant #5 left and returned from each hospitalization.

4. Review of Tenant C1's file on 7/9/24 and 7/15/24 revealed Patient Communication Notes indicating the following:

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- On 7/18/23 an order was received for Keflex 500 milligrams (mg) by mouth, twice daily for seven days for a urinary tract infection (UTI).
- On 7/24/23 a new order was received for amoxicillin 875-potassium clavulanate 125 mg tablet, one tablet by mouth twice daily for seven days for a UTI. It was noted that it would replace the Keflex.
- On 8/11/23 Tenant #5 complained of burning and frequency with urination. She returned from an appointment and had a new order for cephalexin 500 mg, by mouth, twice daily for 10 days.
- On 10/19/23 the hospital called and informed staff Tenant #5 was still being evaluated and there would be x-rays.

The October 2023 medication administration record (MAR) reflected Tenant C1 was in the hospital on 10/20/23 and then went to skilled care. Tenant C1 was discharged on 11/30/23 to a higher level of care.

A review of Incident Reports and the staff communication book indicated Tenant C1 had falls on 9/12/23, 10/13/23, 10/14/23 and 10/19/23.

Nurse's notes were not documented when the antibiotics were completed or when Tenant C1 went to the hospital and the reason for her hospitalization. Additionally, a nurse's note was not documented when Tenant C1 was discharged.

5. Review of Tenant C2's file on 7/15/24 revealed Patient Communication Notes indicating the following:
- On 10/19/23 Tenant C2's family member took her to the hospital for evaluation related to back pain due to falls.

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A 290	Continued From page 12 - A note date of 10/25/23, created on 10/27/23, indicated Tenant C2 had a L5 fracture (burst fracture). She would be discharged from the hospital and would be going to skilled care. - A note date of 11/16/23, created on 11/24/23, indicated Tenant C2 returned to the Program. - A note date of 11/22/23, created on 11/24/23, indicated Tenant C2 was seated on the couch soaked in urine without pants and was confused and unable to answer questions. There were four containers of her meals on the table that were not touched except for one container where she had eaten dessert. She was taken to the hospital. - On 11/24/23 Tenant C2 was admitted with a diagnosis of sepsis without shock, a UTI and encephalopathy. Incident Reports indicated Tenant C2 had a fall on 10/16/23 and 10/17/23. Further record review revealed Tenant C2 was discharged to a higher level of care on 11/30/23. Nurse's notes were not documented timely (late entries) related to Tenant C2's return from a hospitalization and skilled stay, or when she was sent out to the hospital in November. Additionally, nurse's notes were not completed related to her falls in October or when she was discharged from the Program on 11/30/23. 6. When interviewed on 7/17/24 at 3:04 p.m. the Administrator confirmed all nurse's notes were provided for the tenants reviewed.	A 290		
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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(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 350	Continued From page 13 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 that were based on evaluations, and failed to updated service plans as needed to reflect the service needs of the tenants. This pertained to 4 of 5 current tenants (Tenant #1, #2, #4 and #5) and 2 of 2 discharged tenants (Tenant C1 and Tenant C2) reviewed. Findings follow: 1. Review of Tenant #1's file on 7/16/24 and 7/17/24 revealed an After Visit Summary (AVS) reflecting Tenant #1 was hospitalized from 6/23/24 to 7/4/24 for aspiration pneumonia. Diet instructions included soft and bite size foods with moderately thick liquids. Pills were to be administered one at a time in pudding or applesauce and no straws were to be used. Thickened liquids, moderately thick, could be drunk from a cup or eaten with a spoon. The soft and bite sized foods were to be tender and moist throughout with no thin liquid leaking or dripping from the food. The orders indicated biting the food was not required but chewing before swallowing was required. The pieces should be no larger than 15 millimeters (mm) x 15 mm. The food was to be easy to push down with a fork and squashed completely without regaining its shape.	A 350		

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A 350	Continued From page 14 Tenant #1's service plan dated 7/1/24 indicated Tenant #1 made his own snacks and breakfast and he received two meals from Queen Bee's Inc (food provider). Meals were delivered to his apartment per his request. The service plan indicated to use Thick-it for thin liquids as Tenant #1 aspirated on thin liquids. The service plan indicated to use no straws, use Thick-it in liquids to thicken, to drink from cup or spoon. The provider was listed as Tenant #1 and Comfort Care Staff. The service plan did not reflect the other diet orders received as noted above. 2. Review of Tenant #2's file on 7/15/24 to 7/17/24 revealed a Cognitive Ability Assessment dated 2/27/24. A service plan was also dated 2/27/24; however, the service plan was not based on evaluations as the health and functional evaluation was not completed. Continued record review revealed the March, April, and June 2024 treatment administration record (TAR) reflected staff assisted with the application of Tens unit patches, applied at 6:00 a.m. and removed at 8:00 p.m. The service plan most recently signed on 5/23/24 indicated Tenant #2 was independent with medication administration. The service plan did not reflect staff assistance with the Tens unit patches. The Home Health Certification and Plan of Care document indicated her diet was no concentrated sweets and sodium restriction, no added salt. The service plan reflected when she ordered meals they were brought to her apartment. The service plan did not reflect Tenant #2's diet orders. A Patient Communication Note dated 6/12/24 indicated Tenant #2 was going to the doctor on	A 350		

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A 350	Continued From page 15 6/13/24 and the plan was to resume physical therapy (PT) on 6/17/24. The service plan did not reflect PT services. 3. Review of Tenant #4's file on 7/15/24 to 7/17/24 revealed a fax was sent to the primary care provider (PCP) dated 3/7/24 which indicated Tenant #4's medication list was enclosed for review as the tenant wanted the Program to start helping with her medications. A Cognitive Ability Assessment was dated 3/5/24. A service plan was also dated 3/5/24 and reflected Tenant #4 wanted to switch to a medication assist since she was dropping medications; however, the service plan was not based on health and functional evaluations as the health and functional evaluation was not completed. Patient Communication Notes indicated the following: - On 6/21/24 it was noted Tenant #4's buttocks had a pinhole size open area on the left side of the coccyx and there was a small rough area on the opposite side. A clobetasol cream was applied and she was reminded to keep pressure off of the area. - On 6/21/24 it was noted Tenant #4 needed a barrier cream and not clobetasol for her buttocks. A verbal order was received to apply A & D ointment (without zinc), twice daily and as needed. The service plan was not updated as needed to reflect the open area and treatment as ordered. Incident reports indicated Tenant #4 had falls on 4/3/24, 4/21/24, 5/17/24, 5/29/24, 6/16/24, 6/21/24 (x2), 6/28/24, 6/29/24, 7/5/24, 7/13/24.	A 350		

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A 350	Continued From page 16	A 350		

The service plan reflected Tenant #4 was at a high risk for falls; however, did not include interventions related to her falls.

4. Review of Tenant #5's file on 7/16/24 revealed an AVS indicated Tenant #5 was hospitalized from 6/2/24 to 6/4/24 for pneumothorax.

A second AVS indicated Tenant #5 was hospitalized from 6/21/24 to 6/25/24 for acute and chronic respiratory failure with hypoxia. The AVS reflected to limit sodium to 2000 mg per day and a fluid restriction of 2000 total milliters (ml) and 1200 ml with meals.

A third AVS indicated Tenant #5 was hospitalized from 7/9/24 to 7/15/24 for chronic respiratory failure with hypoxia. The AVS indicated a minced and moist diet. It specified very small, moist foods with lumps no greater than 4 mm. Lumps should be easy to squash with tongue. Minimal chewing should be required. The food should be able to mashed with a fork. Excess fluid should be drained from food before draining and it should not be sticky.

The tenant's service plan most recently dated 7/15/24 reflected Tenant #5 was on 3 liters of oxygen per nasal cannula continuously. She had a history of chronic obstructive pulmonary disease. The service plan reflected she received two meals delivered to her apartment and did not like dining in the main dining room. The service plan reflected Tenant #5 was independent with eating. The service plan did not reflect the frequent respiratory issues noted above or the diet orders reflected on the AVS.

5. Review of Tenant C1's file on 7/9/24 and 7/15/24 revealed Patient Communication Notes

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A 350	Continued From page 17	A 350		

indicating the following:
- A note dated 8/8/23, created on 8/923 reflected Tenant C1 had a nosebleed and staff were unable to stop it. Tenant C1 was sent to the ED to evaluate and treat.
- On 8/9/24 Tenant C1 was seen in the ED for a nosebleed. The diagnosis was epistaxis; anticoagulated.

Continued review revealed the staff communication book indicated the following:
- On 10/7/23 Tenant C1 had a nosebleed during lunch.
- On 10/15/23 Tenant C1 reported she had a lot of nosebleeds that day and wanted to talk to the nurse.

The October 2023 medication administration record (MAR) reflected staff administered Eliquis, 5 mg tablet twice daily.

Incident reports and the communication book indicated Tenant C1 had falls on 9/12/23, 10/13/23, 10/14/23 and 10/19/23. The note indicated on 10/19/23, Tenant C1 fell in the kitchen and her right ankle hurt. She was unable to walk and went to the hospital. An order dated 7/14/23 reflected Tenant C1 received PT services in July 2023.

Tenant C1's service plan dated 6/1/23 was not based on evaluations as none were completed at that time. The service plan reflected staff administered Tenant C1's medication; however, did not reflect the anti-coagulant medication and the reoccurring nosebleeds. The service plan reflected Tenant C1 was a high risk for falls; however, did not reflect she had falls and did not reflect PT services.

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A 350	Continued From page 18 6. Review of Tenant C2's file on 7/15/24 revealed Patient Communication Notes indicating the following: - On 10/19/23 Tenant C2's family member took her to the hospital for evaluation related to back pain due to falls. - A note date of 10/25/23, created on 10/27/23, indicated Tenant C2 had a L5 fracture (burst fracture). She would be discharged from the hospital going to skilled care. - A note date of 11/16/23, created on 11/24/23, indicated Tenant C2 returned to the Program. Continued record review revealed a service plan was started on 11/16/23; however, the service plan was not fully completed including the following sections: medication, laundry, nutrition, transportation, housekeeping, emergency response, sleep, orientation, communication, mood/behaviors, activities and other service provider needs. The service plan was not updated as needed post hospitalization and skilled nursing stay. 7. When interviewed on 7/17/24 at 3:04 p.m. the Administrator confirmed all service plans for the tenants reviewed were provided.	A 350		
A 370	481-69.26(3)a Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.	A 370		

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A 370	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtained signed service plans with significant change. This pertained to 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow: 1. Review of Tenant C2's file on 7/15/24 revealed a service plan was signed by a health care professional dated 11/16/23 with a significant change post hospitalization and skilled nursing facility placement. The service plan was not signed by Tenant C2 or Tenant C2's legal representative as needed with significant change. 2. When interviewed on 7/17/24 at 3:04 p.m. the Administrator confirmed all service plans were provided for the tenants reviewed.	A 370		
A 385	481-69.26(3)d Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. d. The service plan updated within 30 days of the tenant's occupancy shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain signed service plans	A 385		

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A 385	Continued From page 20 within 30 days of taking occupancy. This pertained to 1 of 1 discharged tenants reviewed who was admitted in 2023 (Tenant C2). 1. Review of Tenant C2's file on 7/15/24 revealed Tenant C2 was first admitted on 7/27/23. The service plan was signed by the health care professional within 30 days of taking occupancy; however, was not signed by Tenant C2 or Tenant C2's legal representative as applicable. 2. When interviewed on 7/17/24 at 3:04 p.m. the Administrator confirmed all service plans were provided for the tenants reviewed.	A 385		
A 430	481-69.27(1)c Nurse Review 69.27(1) 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: 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; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete a nurse review with a change in health status. This pertained to 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow:	A 430		

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A 430	Continued From page 21	A 430		

1. Review of Tenant C2's file on 7/15/24 revealed Patient Communication Notes indicating the following:
- On 10/19/23 Tenant C2's family member took her to the hospital for evaluation related to back pain due to falls.
- A note date of 10/25/23, created on 10/27/23, indicated Tenant C2 had a L5 fracture (burst fracture). She would be discharged from the hospital and going to skilled care.
- A note date of 11/16/23, created on 11/24/23, indicated Tenant C2 returned to the Program.
- A note date of 11/22/23, created on 11/24/23, indicated Tenant C2 was seated on the couch soaked in urine without pants and was confused and unable to answer questions. There were four containers of her meals on the table that were not touched except for one container where she had eaten dessert. She was taken to the hospital.
- On 11/24/23 Tenant C2 was admitted to the hospital with a diagnosis of sepsis without septic shock, a urinary tract infection (UTI) and encephalopathy.

Review of an investigation completed on 2/12/24 revealed the following statements:
- Staff C's statement indicated on Tuesday 11/20/23 (note that Tuesday was 11/21/23) the former Nurse called Staff C to check Tenant C2's phone. When Staff C entered her apartment, she saw her plant was knocked over. She asked Tenant C2 if she was okay and she said she was fine. She went downstairs to get a phone charger. Once Tenant C2's phone was charged they called her daughter. She went back later to deliver her evening meal and the plant was knocked over again. Staff C asked again if Tenant C2 was okay and she said yes and requested a beverage. Staff C texted the former Nurse and suggested getting a urinalysis (UA) for Tenant C2 and the

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A 430	Continued From page 22	A 430		

former Nurse replied okay. Staff C also told the former Nurse again in person when she saw her later that night. On Wednesday 11/21/23 (note that the following day it was 11/22/23) Tenant C2's daughter called on the intercom for Staff C to let her into the building and into Tenant C2's apartment. She unlocked the door and went to complete her medication pass. She received a telephone call about 15 to 20 minutes later from Tenant C2's daughter to call 911. Staff C and the former Nurse responded. On the way the daughter called and said she would call 911. When Staff C and the former Nurse entered her apartment Tenant C2 was laying on the couch with her protective undergarment around her calves. She was not talking but moved her arms to communicate. She was transported to the hospital via emergency medical services (EMS).

- The Administrator's statement indicated on Tuesday she received a voice message from Tenant C2's daughter who requested to have Tenant C2 call her. It was also noted she also wanted to ensure her phone was charged. The Administrator went to the tenant's apartment and saw her sitting in her wheelchair looking out of the window. Tenant C2 informed her she would call her daughter later. The phone was in the charger. She noticed a plant was knocked over and told her she would ask for staff to clean it up. Tenant C2 said she was fine. The Administrator called Tenant C2's daughter and told her she would be calling her soon. She returned to the apartment after 5:00 p.m. as she forgot to ask staff to clean up the plant and she was going to do so herself. Tenant C2 was still looking out of the window and the plant was cleaned up. Tenant C2 said Staff C had come in and cleaned it. The Administrator indicated both times Tenant C2 did not seem in duress and was quiet per normal.

- The former Nurse's statement indicated she

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A 430	Continued From page 23	A 430		

was informed by staff that Tenant C2's daughter was there and was calling 911. The former Nurse and staff responded to her apartment and the daughter stated Tenant C2 was seated on the couch, soaking wet with no protective undergarment or pants, and appeared to be very confused. The former Nurse asked Tenant C2 what year it was and received no answer; she asked if she knew where she was and she received no answer. The daughter indicated she had put the protective undergarment on her and that there were four containers of lunch and supper on her table that had not been touched. The former Nurse looked and one of the containers had a dessert missing. The daughter was concerned she was not eating.

2. When interviewed on 7/16/24 at 3:39 p.m. Staff C said the former Nurse had asked her to go and charge Tenant C2's phone. Tenant C2 spoke with her daughter and Staff C took her supper. Staff C told the former Nurse that Tenant C2 was a little off and that maybe a UA needed to be done. The former Nurse said okay and she would get one. She sent a text message to the former Nurse and also told her in person. Staff C said she did not think the UA got done. The next day at the time of the medication pass Tenant C2's daughter arrived and found Tenant C2 laying on the couch and she called 911.

When interviewed on 7/17/24 at 3:04 p.m. the Administrator said on Tuesday, Tenant C2's family or another individual had called and asked to speak with Tenant C2. Her phone was not charged, which was not unusual for Tenant C2. The Administrator went to her apartment and she was looking at the window. The plant was knocked over. It was the day prior to her going out to the hospital.

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A 430	Continued From page 24 3. Review of Tenant C2's hospital records on 7/16/24 indicated the arrival date and time to the emergency department (ED) was 11/22/23 at 5:10 p.m.. She was admitted on 11/22/23 and was discharged to a skilled nursing facility on 12/6/23. Hospital records indicated she was transferred to the ED via EMS for evaluation of an altered mental status. It was noted she was severely altered and would not state her name. Tenant C2's family reported they had been trying to call her all day, went to her apartment and found her slumped over. She was found on the couch, with her pants down, incontinent of urine and dark stools in her protective undergarments. She had three meals delivered that had not been eaten. Her blood pressure at 5:22 p.m. was 200/75 and her heart rate was 108. Hospital problems included acute metabolic encephalopathy, acute cystitis with hematuria, sepsis with encephalopathy without septic shock and hypertensive emergency. It was noted Tenant C2 was hypertensive and afebrile. The early sepsis was likely related to either a urinary tract infection or skin fold cellulitis. 4. Tenant C2's file lacked a nurse review completed related to change in health status reported to the former Nurse and also lacked documentation of a UA or the request to the provider to obtain a UA. 5. When interviewed on 7/17/24 at 3:04 p.m. the Administrator confirmed all nurse reviews were provided for the tenants reviewed.	A 430		
A 470	481-69.28(5)a(1)(2)(3) Food Service 69.28(5) Personnel who are employed by or	A 470		

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A 470	Continued From page 25 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. a. In addition to the requirements above, a minimum of one person directly responsible for food preparation shall have successfully completed a state-approved food protection program by: (1) Obtaining certification as a dietary manager; or (2) Obtaining certification as a food protection professional; or (3) Successfully completing an ANSI-accredited certified food protection manager program meeting the requirements for a food protection program included in the Food Code adopted pursuant to Iowa Code chapter 137F. Another program may be substituted if the program's curriculum includes substantially similar competencies to a program that meets the requirements of the Food Code and the provider of the program files with the department a statement indicating that the program provides substantially similar instruction as it relates to sanitation and safe food handling. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure at least one staff responsible for food preparation had successfully completed an approved food protection program. This potentially affected all tenants (census of 52). Findings follow: 1. Record review on 7/9/24 and 7/17/24 revealed	A 470		

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 07/17/2024

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 470	Continued From page 26 there were two dietary staff listed for the contracted food provider (Queen Bee's Inc.) and neither dietary staff had completed a state approved food protection course. Owner #2 had a ServSafe Certification dated 12/4/18 to 12/4/23, which had expired six months prior to the onsite visit. Owner #2 currently did not have a current state approved food protection course. Owner #2 registered for a ServSafe course on 7/10/24 (after the certificate was requested onsite). Owner #2 was scheduled to attend the course on 8/12/24. 2. When interviewed on 7/17/24 at 1:45 p.m. Staff E, a cook, confirmed he had not taken the ServSafe course and did not have a certification. 3. When interviewed on 7/17/24 at 3:04 p.m. the Administrator confirmed all ServSafe certificates available were provided.	A 470		

Irving POINT
AFFORDABLE ASSISTED LIVING

September 13, 2024

Department of Inspections and Appeals
Attn: Deb Dixon
6200 Park Avenue, Suite 100
Des Moines, Iowa 50321

Dear Ms. Dixon:

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 completed on July 17, 2024. 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.
    - *Irving Point will not provide assistance with therapeutic diets, including texture changes such as thickened liquids. Tenants will be independent with management of therapeutic diets. Policy has been updated to reflect this change. Tenants were provided a 30-day notice of the policy change.*
    - *Irving Point's Fall with Head Injury policy will be followed for all tenants who fall and hit their head.*
    - *Staff will complete an incident report as specified in the Incident Reporting policy for tenants who reside at Irving Point.*

2. Measures taken to ensure the problem does not recur.
    - *Comfort Care Nursing and Administration will be re-educated on Irving Point's policy related to therapeutic diets.*
    - *Staff will be re-educated on Irving Point's policy to not provide assistance with therapeutic diets.*
    - *Staff will be re-educated on Irving Point's incident reporting and fall with head injury policy.*
    - *The Nurse will be re-educated on Irving Point's incident reporting and fall with head injury policy. Including, but not limited to, documentation post fall.*

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.*
    - *The Administrator or Designee will review incident reports and tenant documentation at least semi-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 October 3, 2024.*

Evaluation of Tenant

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.
    - *Tenants will have a health, functional, and cognitive evaluation completed as required by regulation and Irving Point policy. A health, functional, and cognitive evaluation will be completed prior to move in, within 30-days of move in, annually, and with a significant change in condition. The initial and change of condition evaluation will be completed by a RN.*
    - *Tenants identified in the regulatory report and who currently reside at Irving Point will have updated health, functional, and cognitive evaluations completed.*

2. Measures taken to ensure the problem does not recur.
    - *The RN will be re-educated on regulatory requirement for evaluation of tenant.*

3. How the Program plans to monitor performance to ensure compliance.
    - *The Administrator or Designee will review tenant files at least semiannually to confirm compliance.*

4. The date by which the regulatory insufficiency will be corrected.
    - *This plan of correction will be completed on or before October 3, 2024.*

Tenant Documents

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.
    - *The tenant record will include nurse's notes as necessary for exceptions.*

2. Measures taken to ensure the problem does not recur.
    - *The RN or Nurse Designee will be re-educated on documentation, including documentation of nurse's notes for exception to "paint a picture" of what is going on with the tenant.*

3. How the Program plans to monitor performance to ensure compliance.
    - *The Administrator or Designee will monitor tenant charts and documentation at least semiannually to confirm compliance.*
    - *The RN or Nurse Designee will monitor tenant charts at least every 90-days when completing a 90-day nurse review.*

4. The date by which the regulatory insufficiency will be corrected.
    - *This plan of correction will be completed on or before October 3, 2024.*

Service Plans

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.
    - *All tenants who reside at Irving Point will have service plans developed that are based on evaluations and identify the tenant's needs and preferences for assistance.*
    - *All tenant service plans will be signed as required by regulation.*

2. Measures taken to ensure the problem does not recur.
    - *The RN or Nurse Designee will be re-educated on regulatory requirements for service plan.*

3. How the Program plans to monitor performance to ensure compliance.
    - *The Administrator or Designee will monitor tenant charts and documentation at least semiannually to confirm compliance.*
    - *The RN or Nurse Designee will monitor tenant charts at least every 90-days when completing a 90-day nurse review to confirm service plans are accurate and identify tenant needs and preferences for assistance.*

4. The date by which the regulatory insufficiency will be corrected.
    - *This plan of correction will be completed on or before October 3, 2024.*

Nurse Review

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.
    - *A nurse review will be completed for any tenant at Irving Point with a change in health status.*

2. Measures taken to ensure the problem does not recur.
    - *The RN or Nurse Designee will be re-educated regulatory requirements for nurse review.*

3. How the Program plans to monitor performance to ensure compliance.
    - *The Administrator or Designee will monitor tenant charts and documentation at least semiannually to confirm compliance.*
    - *The RN or Nurse Designee will monitor tenant charts at least every 90-days when completing a 90-day nurse review to confirm nurse reviews have been completed as required.*

4. The date by which the regulatory insufficiency will be corrected.
    - *This plan of correction will be completed on or before October 3, 2024.*

Food Service

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.
    - *All staff employed by Queen Bees, the contracted food provider, will have completed safe food handling as required by regulation.*

- *Queen Bees, the contracted food provider, will complete the ServSafe Certification as required by regulation. Queen Bees will maintain the ServSafe Certification ongoing.*

2. Measures taken to ensure the problem does not recur.
   - *The Owner of Queen Bees will be re-educated on regulatory requirements for safe food handling and completion of a food protection program.*

3. How the Program plans to monitor performance to ensure compliance.
   - *The Administrator or Designee will monitor staff training and food protection program (ServSafe certification) status at least annually.*

4. The date by which the regulatory insufficiency will be corrected.
   - *This plan of correction will be completed on or before October 3, 2024.*

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

Sincerely,

Sally Page
Administrator