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
	S0405	A. BUILDING: ______ B. WING ______	C 04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEY POINT MEADOWS	**1900 STONEY POINT ROAD SW CEDAR RAPIDS, IA 52404**

(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 for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 77 Number of tenants with cognitive impairment: 17 Total census: 94 There were no regulatory insufficiencies cited related to the investigation of Complaint #125163-C. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific 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 policy and procedure related to the completion of incident reports. This pertained to 2 of 8 current tenants reviewed (Tenant #5 and Tenant #7). Findings follow: 1. Review of Tenant #5's file on 4/7/25 revealed Progress Notes indicating the following: - On 1/31/25 during a shower there was bruising noted on Tenant #5's breast. The bruising was light purple, dark purple and was yellowing. She	A 150	Re-education will be provided to nursing staff by 5/12/25 on incident report policy. RN will review daily notes and communication forms to ensure incident reports are completed per policy.	

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		

did not have a witnessed injury. Tenant #5 wandered often and bumped into things in the past.

- On 2/26/25 staff noticed a large bruise to Tenant #5's left anterior lower leg. It was not tender and was purple, yellow and blue in color. Tenant #5 had a history of bruising and bumping into things. Tenant #5 was not able to state what had occurred.
- On 3/25/25 Tenant #5 had a linear skin abrasion to the left side of her neck. Her finger nails were clean and there was no evidence of an altercation. Tenant #5 was independent with ambulation, wandered in the memory care unit often, had a history of bumping into things, bruising and injuries.

Continued record review revealed an incident report was completed dated 3/25/25, related to the the linear abrasion noted to the left side of her neck. Incident reports could not be located for 1/31/25 and 2/26/25 related to the bruising of unknown etiology.

2. Review of Tenant #7's on 4/7/25 file revealed a Progress Note dated 3/2/25 indicating staff called and reported that while providing cares to Tenant #7 they noticed a new bruise on the back of her upper right arm. Tenant #7 said she received the bruise from a fall a few days prior. The bruise was purple and red in color.

An incident report could not be located for 3/2/25 related to the discovery of bruising and a reported fall that happened days prior.

3. On 4/7/25 review of the Program's policy and procedure related to incident reports indicated all staff who provided services would report any accident or injury to a tenant. The Program would

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A 150	Continued From page 2 complete a detailed report. Examples of the incidents that required an incident report included falls, elopements, skin concerns (bruise or skin tear) and medication errors. All incident reports would be completed immediately upon discovery. 4. When interviewed on 4/7/25 the Director of Health Services confirmed there was not an incident report completed related to Tenant #7's bruising. She said there had not been a reported fall with Tenant #7 and she ambulated independently. She said there was an incident report related to the scratch for Tenant #5. She said Tenant #5 ran into things and it was not new.	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 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 observation, interview and record review the Program failed to update service plans as needed to relect the needs of the tenants. This pertained to 1 of 8 current tenants reviewed (Tenant #1). Findings follow: 1. When observed on 4/3/25 at approximatley	A 350	This item was accidentally overlooked. There is a tool in place to ensure service plan identifies if staff is managing medication. Re-education was provided to nurses on 5/6/25 to ensure they are utilizing service plan tool to prevent overlooking identified services.	

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A 350	Continued From page 3 11:00 a.m. Tenant #1 received staff administration of oral medications, an inhaler and a topical medication. Review of Tenant #1's file on 4/3/25 and 4/7/25 revealed the comprehensive evaluation dated 3/3/25 indicated staff managed her medications. The medications were stored in the tenant's apartment in a locked medication cupboard. The tenant's Resident Plan of Care (service plan) dated 3/10/25 did not reflect staff administered Tenant #1's medications. 2. When interviewed on 4/7/25 the Director of Health Services confirmed medication management was not reflected on Tenant #1's service plan.	A 350		