DEPARTMENT OF INSPECTIONS AND APPEALS

ok

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 The following regulatory insufficiencies were cited during the investigation into Complaints #109572-C, #111127-C, #111768-C, #111901-C, #112046-A and #112062-A.	A 000	See Attached POC 11/2/23	
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide care and treatment which were adequate to 4 of 5 discharged tenants reviewed (Tenants C2, C3, C4 and C5). Findings include: 1) Record review on 3/29/23 revealed Tenant C2 moved to the program on 1/26/23. Tenant C2 had a discharge packet from the nursing facility in which he was living. Tenant C2 was diagnosed with difficulty in walking, need for assistance in personal care, restlessness and agitation, diabetic peripheral angiopathy without gangrene, other fracture of left lower leg, subsequent encounter for closed fracture with routine healing, type II diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema. Tenant C2 was wearing a cast when a resident of the nursing facility due to having a fracture of the left lower leg.	A 160		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 160	Continued From page 1	A 160		

Tenant C2 had an assessment completed on 1/20/23 in which his functional abilities and health needs were identified by the Director of Nursing (DON). The DON noted Tenant C2 was independent with dressing, bathing and ambulation. An assessment of his physical health noted Tenant C2 ambulated without assistance or use of walking devices. Tenant C2's skin was noted to be in good condition with no open wounds and he was able to monitor his skin and apply lotions independently.

Tenant C2 went to the orthopedic surgeon on 1/25/23 and was assessed for a closed fracture of the left ankle with routine healing. Tenant C2 was fit for a left pneumatic walking boot. He was shown how to take it on and off. Tenant C2's skin was in good condition with his lower leg wound healed. His medial eschar was very superficial. There was no erythema and no to very little swelling noted. Eschar is dead tissue that sheds or falls off from the skin. It's commonly seen with pressure ulcer wounds.

Observation reports for Tenant C2 dated 1/29/23 noted he requested a shower on 1/29/23. Staff covered his boot with a garbage bag and his shower was completed. Later that day, Tenant C2 was cutting his pants to the point he could not wear them. Staff found and removed the scissors. Resident C2 refused to have his weight checked on 1/30/23 and refused medication on 1/31/23. Resident C2 cut up another pair of pants on 2/5/23. On 2/6/23, Resident C2 slapped at a staff member when she asked to test his blood sugar at lunch.

Tenant C2 was admitted to the hospital on 2/10/23 with cellulitis about the medial ankle and admitted for IV antibiotics. According to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 160	Continued From page 2	A 160		

records, X-rays of the ankle obtained in the emergency department were well-appearing. Resident C2 had wounds to his left medial ankle, left medial foot and left heel. Per Tenant C2 and his son, Tenant C2 was leaving the walking boot on at all times. Tenant C2 was unaware of his skin breakdown to his left medial ankle and foot due to severe neuropathy. Tenant C2 did report feeling pain to his left heel several days prior to his admission. He reported his pain was 8 out of 10 during ambulation or if his heel was touched.

On 2/13/23, an assessment of Tenant C2's wounds were as follows:
Left medial ankle, left medial foot:
Etiology: Pressure, friction
Measurements: 9.5x4.1.0.1 cm cluster
Stage of wound if suspected to be pressure related: Unstageable, at least stage III

Left heel:
Etiology: Pressure
Measurements: 1.6x.5 cm cluster
State of wound if suspected to be pressure related: Unstageable, at least stage III

Tenant C2 returned to the program on 2/14/23.

On 3/29/23 at 2:50 PM, Staff B reported Tenant C2's daughter came in and took his boot off, it smelled like rotten flesh. His daughter came in and Tenant C2 was pointing to his foot. The daughter took his shoe off and it smelled horribly. Staff B recalled Resident C2 would come out of his apartment and say he was supposed to have a shower. One day the agency staff person forgot to put the sock in his walking boot.

On 3/29/23 at 4:30 PM, the Executive Director stated she felt like they failed Tenant C2. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 160	Continued From page 3	A 160		

said Tenant C2 was admitted when the DON was out from 1/25/23 - 1/29/23. The Vice President of Nursing did the intake by phone on 1/26/23. The DON sent the Executive Director a picture of Tenant C2's foot on the day he was sent out to the hospital (she showed a picture of an infected appearing ankle and heal). There was also a picture of the boot he wore with staining down the side where his ankle was. The Executive Director said she was so upset with the Director of nursing (DON). Upon Tenant C2's return to the program, she made sure the DON wrote down everything on the discharge report on the service plan. The Executive Director was not sure the DON checked on Tenant C2 at all to address his wound when he came to the program initially. She said she knew this was important because her mother had fractured both her ankles the summer before and how quickly wounds could develop.

On 3/30/22 at 9:25 AM, Staff D reported to the DON her concerns about Tenant C2 not removing his walking boot when he first moved to the program. The DON said she would follow up on her concern but Staff D was not sure if the DON ever did.

On 3/30/23 at 9:10 AM, Staff E reported she asked Tenant C2 about taking his walking boot off because it would be easier to help change his clothes. He told her no, the doctor wanted him to keep it on. Staff E talked to the DON about this because she was concerned. About two days later, the DON told Staff E Tenant C2 was hospitalized for an infection to his ankle.

On 4/5/23 at 4:00 PM, the Float Nurse reported general practice is if a tenant moves to the program when the DON is out of the building, any new orders will be sent to the on-call nurse. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 160	Continued From page 4	A 160		

next day the DON is in the building, she will come and assess the new tenant. They may find new needs they were not aware of when the tenant was initially assessed. They will get new vitals. The DON should look over new paperwork to ensure nothing is missing. The Float Nurse verified Tenant C2's admission paperwork did not appear to be reviewed by the DON. This is standard nursing practice to initial after reviewing paperwork. There were no notes from the DON from 1/26/23 - 2/13/23 indicating she visited Tenant C2, stating she did the initial assessment, stating he was sent out to the hospital on 2/10/23, or the DON took a picture of his ankle on 2/13/23 but made no note about it.

On 3/30/23 at 11:40 AM, Staff C reported Tenant C2 fought on cares, taking his medication and taking his boot off. At first she was not concerned about the boot until she noticed a yeasty smell. She wasn't doing too many of his cares.

On 6/13/23 at 10:45 AM, the nurse at the orthopedic surgeon's office confirmed they should be monitoring his skin at the program based on the doctor's report of medial eschar on Tenant C2's skin.

On 6/7/23 at 12:07 PM, the Vice President of Nursing confirmed the DON should have completed a physical assessment of Tenant C2 on her return to the program on 1/30/23, especially considering he was diabetic and already having documented blood glucose control issues and unusual behaviors. The expectation is for staff to read the recent notes at the beginning of every shift, and especially after having been out of the building for an extended period. If the DON would have read the notes she would have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 160	Continued From page 5	A 160		

known he was having a difficult time settling in and was not medically stable.

2) Tenant C3 was admitted to the program on 12/20/22. Tenant C1 was diagnosed with Alzheimer's disease and Acute embolism and thrombosis of unspecified deep vein of unspecified lower extremity. Tenant C3 was prescribed Xarelto, 20 mg. and administered at 8:00 AM daily. He received his Xarelto from 12/21/22 - 1/1/23. It was marked refused on 1/2/23, not passed per nurse on 1/3/23, unable to give on 1/4/23 and out of the facility on 1/5/23.

A review of progress notes indicated on 1/2/23, staff were unable to rouse Tenant C3 on 1/2/23. He was lethargic and unable to bear any weight while transferring. While repositioning Tenant C3, staff noticed a large red welt on his right posterior thigh, which was hot to the touch, hard and very swollen. Staff notified the DON. The DON documented on 1/6/23, she was worried about a blood clot and called Tenant C3's son and informed him of this. Tenant C3's son stated he did not want his father sent out and they should monitor this. The DON contacted staff, let them know to monitor the situation and draw a circle around the red area.

The DON documented Tenant C3 was stable but tired and able to arouse with stimuli on 1/3/23. The Behavioral Recovery Outreach Team from the VA was there and looked at his leg and agreed to the recommendations given to staff with no new orders from the VA. Tenant C3's son called and the DON sent him a message letting him know his father was all right.

On 1/4/23, the medication aide documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 160	Continued From page 6	A 160		

Tenant C3 was still lethargic, unable to transfer himself or hold his weight up. He was in bed and staff were repositioning him for comfort. The nurse was aware. The nurse documented she called Tenant C3's son to let him know his dad was okay but remained sleepy.

On 1/5/23, staff noticed fluid-filled blisters on his right forearm with redness leading to his hand and up his arm. There was a small abrasion on his right elbow with redness surrounding it. The nurse was notified and Tenant C3 was sent to the hospital.

Tenant C3 was admitted to the hospital with diagnoses of saddle embolus of pulmonary artery, acute embolism and thrombosis of right auxiliary vein, c difficile diarrhea, moderate dehydration, severe sepsis without septic shock, cellulitis of the right arm, pressure injury of the right elbow, stage 3, pressure-induced deep tissue damage of the sacral region and pressure injury of deep tissue of right buttock.

On 3/29/23 at 2:00 PM, Staff A stated she tried to document as much as she could about Tenant C3. The situation was weird. He was fine one second and then he was sleeping. His symptoms were strange. She had worked at the program a long time and hadn't seen someone just sleep. Tenant C3 fell asleep on the couch. Staff said he fell asleep on the couch but then he didn't wake up. She wanted to get him back to his room. It took three employees to get Tenant C3 back to his room. He was non-verbal but normally he could transfer on his own. They took him in the wheelchair back to his bed. It all happened in about a week. Staff A let the DON know it took three of them to get him in bed and it was not normal. They got his vitals. They were worried

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 160	Continued From page 7	A 160		

about him. To the best of her recollection, she doesn't recall the DON checking on Tenant C3. She worked a second shift and saw a red bump on Tenant C3 and called the DON. The DON called Tenant C3's family and they decided not to send him out, to wait for the BRO team to come. Tenant C3 was pocketing his medication. She could see the pills coming out of the side of his mouth. She was worried Tenant C3 would aspirate. She was unable to recall the DON telling her not to give Tenant C3 medication. Tenant C3 was not verbal so that made it more difficult to understand his cues.

On 3/29/23 at 2:50 PM, Staff B said she did not see the DON check on Tenant C3. Tenant C3 was fine when he admitted to the program. It was not unusual for him to sleep on the floor. They sat next to him to watch him. But then, Tenant C3 laid in the floor for more than four days. He wasn't taking his medication. He declined badly. The DON wasn't checking on Tenant C3 regularly. He had a bedsore on his butt, he did not have at first. He laid in his bed. She told the DON he needed to be sent out. Everyone told her this. We said there was something wrong with him and she said he was fine. He was not eating, drinking or taking his medication.

On 3/28/23 at 2:06 PM, Staff C reported Tenant C3's sore ended up turning into a wound. She sent a message about this to the DON. She expressed concerns about him at least three days before he was sent to the hospital. Prior to Tenant C3 becoming ill, he was an extreme mover. The first time she assisted Tenant C3 to bed, they informed the DON Tenant #3 was not eating or drinking. On the second day they said he's not eating or drinking. They also informed her they did not think 3rd shift was rotating him.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 160	Continued From page 8	A 160		

She never saw the DON come down and assess him. Staff C did not think Tenant C3 was able to take medication when he was sick. He might have been able to the first day he was ill, but not on the 4th or 5th of January. Staff C reported the DON was notified of this information.

Tenant C3 received outpatient services from the VA. A progress note dated 1/3/23 indicated a VA team member met with the DON who reported Tenant C3's leg was more swollen than the left with a reddened and hardened area. She stated the family did not want the program to take Tenant C3 to the ER unless it was an emergency. The DON reported Tenant C3 was followed by the facility medical provider and she would try to get the provider to come over before the usual visit day (1/5/23). The DON said if necessary, Tenant C3 could have a leg scan done at the building. The VA offered to coordinate care. The DON said she would be in touch regarding the coordination of services.

There was no documentation regarding coordination of services in the record or attempts to reach the program's medical provider.

Tenant C3 presented at the emergency room on 1/5/23. He was diagnosed with severe sepsis without septic shock, cellulitis superimposed on herpes zoster rash, hypernatremia and dehydration. Tenant C3 died on 1/13/23.

3) Tenant C4 and Tenant C5 were a married couple who shared an apartment at the program. A review of Observation notes for Tenant C4 revealed on 1/4/23, she was having bowel incontinence, which was unusual for her. It was upsetting for her. Staff A helped her take a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 160	Continued From page 9	A 160		

whirlpool bath and get cleaned up.

On 1/6/23, Tenant C4 was seen in urgent care for dizziness and acute cystitis. She was started on an antibiotic and a medication to treat nausea. A note from Tenant C4's Primary Care Physician (PCP) indicated after Tenant C4 was seen on 1/6/23 in urgent care, she was sent to the emergency room for an evaluation. Tenant C4 was diagnosed with Influenza A and prescribed Tamiflu.

On 1/13/23, caregivers found Tenant C4 in the hallway where she seemed very confused and unsure about her surroundings. She was redirected back to her room. This was out of character for her to be so confused. An hour and a half later, Tenant C4 vomited up her morning pills. Staff gave her a shower. The nurse was notified. Tenant C4 met with her PCP again on 1/16/23. Tenant C4 continued to report fatigue. Tenant C4's weight dropped 16 pounds from the previous month. The note indicated Tenant C4 denied nausea or vomiting. On 1/17/23, Staff noted Tenant C4 was having a hard time swallowing larger pills. Normally she would take her pills all at once but that day she took them two at a time. Staff noticed a red rash under Tenant C4's breast when giving her a bath on 1/19/23. There were no notes in the chart indicating she was hospitalized.

Tenant C4 was admitted to the hospital on 1/19/23 according to hospital records. Approximately 10 days ago her family noted she seemed confused and was having gibberish conversations at times. This worsened over the last 5-6 days. Normally Tenant C4 was alert to self and place and can identify family members but was unable to do any of these things. Tenant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 160	Continued From page 10	A 160		

C4 was diagnosed with acute kidney injury acute encephalopathy. Tenant C4 was discharged to a nursing facility on 1/25/23.

There was no documentation the DON notified the PCP of Tenant C4's increasing confusion, weight loss prior to 1/16/23, or vomiting.

Tenant C5 met with his PCP on 1/9/23 at the program. Tenant C4 and C5 shared the same PCP. Tenant C5 was noted to have some coughing and a decrease in oral intake. His breathing was not labored. Tenant C5 would be treated for Tamiflu as his wife was diagnosed with Influenza A days earlier.

Tenant C5 refused orals cares the evening shift of 1/12/23 and 1/15/23 and was noted to be in bed all shift. On 1/16/23, Staff A noted she had a very hard time convincing Tenant C5 to take his medication in the morning. It took multiple caregivers, his son and about 30 minutes of prompting for him to take his medication. He refused to sit up in bed and became agitated when asked to do so. Resident C5 refused his evening room tray on 1/16/23.

Tenant C5 saw his PCP on 1/16/23. It was noted he lost 10 pounds from November, 2022 to December, 2022. Tenant C5 refused to have his weight taken by staff. Staff reported abdominal issues and lack of appetite. Tenant C5 was coughing. The PCP contacted Tenant C5's POA who shared these concerns.

Tenant C5 refused to sit up or take his morning pills on 1/17/23. He gagged and had a hard time swallowing them. Tenant C5 did not get out of bed the evening shift on 1/17/23. There were no notes in the chart from 1/17/23 - 2/5/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 160	Continued From page 11 Tenant C5 was admitted to the hospital on 1/18/23 with complaints of increasing confusion from his baseline dementia, obvious respiratory distress on arrival, hypoxic at 84% on 6 L via nasal cannula. He did have decreased lung sounds, wheezing throughout, somewhat improved with DuoNeb in the emergency department. Tenant C5 was diagnosed with sepsis with acute hypoxic respiratory failure without septic shock, due to unspecified organism, pneumonia of both lower lobes due to infectious organism, hypoxia and pneumonia. He was discharged to an intermediate care facility with hospice on 1/25/23. On 3/22/23 at 2:50 PM, Staff E stated she had concerns when Tenant C4 and Tenant C5 got sick. She told the DON they weren't eating and they never got better. Staff E kept telling the DON the tenants weren't getting better. When she was at the program, the DON didn't assess them. She thinks they had the flu and were on medication for the flu for 3 days, and Staff E got concerned after 3 days. From what she recalled, she talked to the DON after day two of symptoms as both Tenant C4 and Tenant C5 were not eating and had a hard time swallowing pills. On 3/23/23 at 1:00 PM, Staff D recalled Tenant C4 had swallowing difficulties. They both refused to eat. The tenants had no energy and wouldn't come out of their room. Before this, Tenant C4 was a social butterfly. Tenant C4 seemed to have confusion and depression and couldn't remember where her room was by the second week. By the end of the month, they decided to send them out. They were doing daily reports to the nurse on their condition.	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 160	Continued From page 12 On 3/28/23 at 2:06 PM, Staff C said prior to getting ill, Tenant C4 and Tenant C5 were mostly independent. When Tenant C4 got sick, we were told to do hourly checks and give them water. Apparently the DON called family and family didn't want to send them out. Tenant C4 was taken to the emergency room and had influenza. There was one time after Tenant C4 was diagnosed with Influenza A when an employee found her on the ground. It was after the diagnosis they were told the family did not want them sent out. We told the DON about Tenant C4 was not eating. This was unusual for her. It was not unusual for Tenant C5 not to eat or drink well, but he would eat small portions and eat the dessert. Tenant C5 did refused medication and it took a lot of convincing to get medication down him. Tenant C5 was not regularly incontinent. When they got sick, they began having incidents of incontinence and were not aware of this. After being sick, Tenant C4 became pretty confused. The DON said something like, okay, family knows, they have influenza, do your hourly checks. She did not see the DON assess them. On 3/28/23 at 1:40 PM, the Culinary Services Manager reported he had concerns with Tenant C5 not eating prior to his hospitalization. The Culinary Services Manager shared with the DON Tenant C5 had not eaten for three days. He did not know what the DON did with this information. On 3/29/23 at 2:00 PM, Staff A stated Tenant C4 was pretty independent. When they took to for treatment of the urinary tract infection, Tenant C4 was already not feeling like herself. They slept a lot. She knew Tenant C4 did not feel well when she did not come out for meals or activities all done up. When ill, she was throwing up her med's. She was throwing up bile. Staff A tried to	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 160	Continued From page 13 crush up the pills and Tenant C4 did not like this. They were not told to give Tenant C4 the spermicide. She was frustrated staff were giving her the decussate in the IHS when she was having so much diarrhea and was embarrassed. She had a conversation with the DON about this and also documented about it. Normally Tenant C4 and Tenant C5 came out to the dining room but not when they were sick, so they were pushing water, crackers and soup. They worried about dehydration. Tenant C4 was so nauseous and she refused food. She became pretty confused and came out of her room looking for her kids and did not know where she was. On 3/29/23 at 2:50 PM, Staff B said the DON failed Tenant C4 and Tenant C5. She told the DON Tenant C4 was dehydrated. The DON said to keep pushing fluids. But Tenant C4 kept vomiting and there was no way to keep her hydrated. Taking a sip and a bite was not getting her hydrated. On 6/19/23 at 4:00 PM the Executive Director confirmed the program did not address the tenants' needs.	A 160		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner	A 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 285	Continued From page 14 or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to administer medication as ordered to 2 of 6 current and discharged tenants reviewed (Tenant C1 and Tenant #1). Findings follow: 1) Record review on 3/29/23 revealed Tenant C1 returned to the program from a hospitalization on 9/27/22. According to a note from his PCP (Primary Care Provider) dated 9/28/22, Tenant C1 was admitted to the hospital on 9/20/22 for acute respiratory insufficiency. He had a discharge diagnosis of non-ST-elevation myocardial infraction (type of heart attack), pulmonary fibrosis and community acquired pneumonia. Tenant C1 was prescribed continuous oxygen, but needed as much as 15 L of oxygen while in the hospital. Tenant C1 was discharged with orders for 2 L of supplemental oxygen via nasal cannula to keep his oxygen saturation level greater than 90%. Tenant C1's MAR (Medication Administration Record) revealed the Director of Nursing (DON) did not begin Tenant C1's discharge medication until 9/29/22 or 9/30/22. Tenant C1 was also started on aspirin, clopidogrel, pantoprazole, polyeth glycol powder and prednisone. Tenant C1 was prescribed Trimethoprim/Sulfamethoxazole, a medication used to treat bacterial infections. Tenant C1 also was prescribed Ipratropium/Sol Albuter, inhale 1 vial via nebulizer four times daily for 30 days. Ipratropium/Sol Albuter is used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by	A 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 285	Continued From page 15	A 285		

lung diseases such as asthma and chronic obstructive pulmonary disease. Tenant C1 was prescribed Budosenide Sus. 0.5 mg./2, inhale one vial via nebulizer every twelve hours for 30 days. It works directly in the lungs to make breathing easier by reducing the irritation and swelling of the airways. This medication must be used regularly to be effective. It does not work right away and should not be used to relieve sudden asthma attacks. As well as not adding this medication to the MAR until 9/29/22, staff could not administer it until 10/4/22 because the program did not access a nebulizer machine for him until that date. There was no documentation in the record from the Director of Nursing (DON) she attempted to access a nebulizer prior to 10/4/22.

A review of observation notes revealed on 9/30/22, Tenant C1 would not leave the nasal cannula in his nose. On 10/2/22, staff noted numerous times throughout the day Tenant C1 would either take his oxygen out or start to chew on it. On 10/3/22, staff documented she had attempted often to get Tenant C1 to keep his oxygen in. Once she left the room he would take it off and either chew on it or throw it on the floor.

An after visit summary from Resident C1's hospitalization on 9/20/22 - 9/27/22 noted his discharge medications should have been administered the evening of 9/27/22 or the morning of 9/28/22. The after visit summary was initialed by the DON on 9/28/22 indicated she reviewed the material.

On 4/5/23 at 3:55 PM, the pharmacy reported they received the medication orders on Resident C1 on 9/28/22 from the program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 285	Continued From page 16 On 4/6/23 at 9:14 AM, Tenant C1's power of attorney (POA) stated he was contacted by the DON about two days after tenant C1 left the hospital, to the best of his recollection. The DON told him she just got the order for Tenant C1 to have a nebulizer. She suggested they get it from a specific medical supply company, one which he was not aware of prior to the call and believed it was one used by the assisted living program. The POA was not told the program was having a difficult time getting a nebulizer. If he had been told, he would have gone out and found a nebulizer on his own. He did not know Tenant C1 went almost a week without the nebulizer. On 10/3/22 at 7:15 PM, staff documented at 7:00 AM, Tenant C1 experienced shortness of breath, had a change of color to his hands and face. She called 911, the nurse and Tenant C1's son. She noted according to the paramedics, Tenant C1's new oxygen level was 5 liters instead of 2 liters. She talked with the nurse about getting a different mask for Tenant C1 for his oxygen. On 10/5/22 at 12:30 AM, staff documented Tenant C1 was really having trouble breathing and seemed to be in pain. At 4:15 PM, staff documented Tenant C1 was sent to the hospital. His oxygen saturation level was 40 and his pulse was 41. Tenant C1 was scared and asked for his son. They comforted him until emergency services arrived. The DON documented Tenant C1 was transferred to Mercy Medical Center. Tenant C1 died at the hospital on 10/7/22 at 12:45 AM. On 3/29/23 at 2:50 PM, Staff B reported Tenant C1 could not breathe. She told the Director of Nursing Tenant C1's oxygen machine was blinking. Tenant C1 was so scared. We kept	A 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 285	Continued From page 17	A 285		

saying he needed to go out. On 10/5/23, Tenant C1's lips were blue. The DON would not come down and check on him. The DON was in the building but did not come down and assess him. Other staff were saying how concerned they were about him.

Staff B said there was no nebulizer until 10/4/22. She talked with other staff who signed the MAR prior to 10/4/22 indicating they administered the medication even though it was not available, to let them know this was not an acceptable practice. Staff B got the nebulizer machine out of the box and administered the first dose to Tenant C1 on 10/4/22.

On 3/30/23 at 11:15 AM, Staff A described one time the ambulance took Tenant C1 to the emergency room and the other time his son took him. Staff A offered to document the situation, but the DON said she would do so. Staff A later realized there was no documentation of the incident in the record. The morning the paramedics came to get Tenant C1, the DON assessed him. She couldn't remember if the DON did so any other other time.

Staff A said Tenant C1 struggled to breathe quite a bit of the time the last week he lived at the program. She reported this to the DON. It was hard to watch someone like that. It made Tenant C1 very confused. They had no information as to why the nebulizer didn't show up. Tenant C1 was so confused by that time, he kept chewing on the oxygen cord or had it disconnected for the oxygen canister.

On 3/30/23 at 11:40 AM, Staff C stated she asked the DON what was going on with the nebulizer for Tenant C1. Staff C reminded the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 285	Continued From page 18	A 285		

DON they couldn't do nebulizer treatments for Tenant C1. They couldn't keep the oxygen on Tenant C1, of which the DON was also aware. Tenant C1 had a nasal cannula. She does not remember the DON assessing Tenant C1. Staff were not allowed to call family or the ambulance regarding a tenant, so the DON would have had to be aware of Tenant C1's condition.

On 6/7/23 at 10:15 AM, the Vice President of Nursing reported Resident C1 had an order for oxygen at 2l/min to keep his oxygen saturation levels >90%. She said they do not usually monitor Sa02 unless there is a specific order or if the person is symptomatic. However, with the way this order is written, and since Resident C1 had just been discharged from the hospital, she would have expected the DON to have a scheduled monitoring of the Sa02. The DON was not monitoring Resident C1's oxygen saturation levels.

On 4/5/23 at 3:15 PM, the float nurse reported when a resident came back from the hospital they faxed the discharge papers to the pharmacy. Then the nurse checked to make sure the pharmacy entered the orders correctly. It appeared the DON didn't provide the information to the pharmacy promptly.

2) Tenant #1 was a 64 year old male diagnosed with dementia in other diseases, classified elsewhere with behavioral disturbance; anxiety disorder, unspecified; and paroxysmal atrial fibrillation. According to Tenant #1's December, 2020 MAR, he was prescribed Morphine Sulfate Solution 100/5 ml. by mouth every two hours as needed. Tenant #1 was also prescribed 0.5 ml of Lorazepam Concentrate 2 mg./ml by mouth or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 285	Continued From page 19	A 285		

under the tongue every one hour as needed.

Staff B completed an incident report on 12/8/22 at 1:37 AM for Tenant #1. Staff B walked into Tenant #1's apartment and he was having a seizure. The first seizure lasted five minutes and the second seizure lasted one minute. Tenant #1's blood pressure was 104/48. His pulse was 78. Tenant #1 was transferred to the emergency room by ambulance. A review of medication administered in the twelve hours prior to 12/8/22 at 1:37 AM did not include Morphine Sulfate or Lorazepam Concentrate.

Tenant #1's nurse review dated 10/16/22, indicated he recieved Hospice care that included medication for pain management.

On 3/29/23 at 2:50 PM, Staff B reported Tenant #1 had two seizures on 12/8/23. They said he had been having seizures earlier that day and said they could not find his Lorazepam and morphine. She called the DON, who reportedly told Staff B to call Tenant #1's POA. The DON did not tell Staff B the Morphine was in her office.

On 3/29/23 at 2:00 PM, Staff A stated when Tenant #1 had his episodes, staff were to give him his medication for comfort. Tenant #1 appeared to be in pain as his eyes would roll back, his body would stiffen, and he had bitten his tongue. The medication really helped with his pain. There was a time the medication went missing on 2nd shift. That situation was concerning because why wouldn't they have comfort medication for him when he needed them. Tenant #1 deserved to be comfortable.

On 3/29/23 at 10:40 AM, the Hospice Registered Nurse (RN) reported the DON told him she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 285	Continued From page 20 locked up Tenant #1's medication because the staff would give him the morphine willy nilly and he would be overly tired at supper time. On 3/29/23 at 10:45 AM, the Executive Director stated the DON told her the Morphine was locked in her office as the bottle did not have packaging on it identifying Tenant #1. She was not told anything about staff giving Tenant #1 too much medication. On 4/5/23 at 3:15 PM the Float Nurse reported Tenant #1's medications should not have been out of the medication cart or refrigerator. As a nurse, the DON should have known the medication should not be stored in her office because they needed to be counted.	A 285		
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 maintain documentation in the tenant record for 4 of 6 current and discharged tenants reviewed (Tenant #1, Tenant C1, Tenant C2 and Tenant C4). Findings follow:	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 290	Continued From page 21 1) Record review on 3/23/23 revealed Tenant #1's incident report indicated he was transported to the hospital by ambulance on 12/8/22 around 1:30 AM. A review of the observation report made no mention of the hospital visit or discharge instructions. 2) An observation note from staff noted on 10/3/22, Tenant C1 had shortness of breath, a change of color, hands and face. Staff contacted 911 and the nurse. There were no notes in the record about what occurred with Tenant C1. 3) Tenant C2 moved to the program on 1/26/23. On 4/5/23, the Executive Director reported Tenant C2 had a cast removed prior to moving to the program and discharge from a nursing program. Tenant C2 wore a walking boot when he entered the program. There was no documentation of this in the observation report. According to an assessment completed in the hospital on 2/10/23, Tenant C2 was assessed with wounds to his left medial ankle, left medial foot and left heel. He had cellulitis about the medial ankle and was treated with IV antibiotics. There was no documentation in the record about Tenant C2's hospitalization from 2/10/23 - 2/14/23 or the need for wound treatment. 4) A review of an After Visit Summary dated 1/6/23 revealed Tenant C4 was treated in the emergency room on that date for dizziness and acute cystitis without hematuria. Tenant C4 met with her PCP (primary care provider) on 1/16/23. The PCP documented Tenant C4 was recently diagnosed with Influenza A and finished a course of Tamiflu. Tenant C4 was noted to have lost 15 pounds since the previous month. There was no documentation in the record of Tenant C4's trip to	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 290	Continued From page 22 the emergency room on 1/6/23 or diagnosis of Influenza A. The Executive Director confirmed these findings on 4/10/23 at 11:50 AM.	A 290		
A 420	481-69.27(1)a 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: a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to conduct nurse reviews every 90 days or with a change of condition for 4 of 6 current and discharged tenants reviewed (Tenant #1, Tenant C2, Tenant C4 and Tenant C5). Findings include: 1) Record review on 3/23/23 revealed Tenant #1 had a 90-day assessment completed on 10/16/22. According to the assessment, the next scheduled review was due on 1/14/23. The program did not complete an assessment until	A 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 420	Continued From page 23 3/1/23. 2) A review of Tenant C2's record revealed he was discharged from the hospital on 2/14/23 with wounds to his left lower extremity. Recommendations for wound care included: - Left medial ankle and left medial foot twice per day wound care. - Left heel dressing change weekly or sooner if dressing was 75% saturated with drainage. - Suspend Tenant C2's heels off of all surfaces using a pillow under each of the lower legs. - Perform skin care daily to both lower legs and inspect daily for discoloration or signs of breakdown. - Ensure Tenant C2 is turning from side to side every two hours while in bed. The program did not conduct a nurse review upon Tenant C2's discharge from the hospital. 3) Tenant C4 had a 90-day nurse review completed on 7/22/22 with a note indicating the next due date was 10/20/22. Tenant C4 had no other nurse reviews in her record. 4) Tenant C5 had a Nurse Review completed on 7/23/22. The next review was due on 10/16/22. Tenant C5 had no other reviews in his record. The Executive Director confirmed these findings on 4/10/23 at 11:50 AM.	A 420		

CountryHouse Residence

Cedar Rapids

Citation #: 10043

Plan of Correction

A160 Tenant Rights

Residents have the right to receive care, treatment and services which are adequate and appropriate.

All care tasks will be individually assigned to each tenant based on the initial assessment completed by the Delegating Nurse or her designee. Documentation of tasks performed will confirm the assigned care has been provided by program staff, per Delegating Nurse directions. Tenant Assessment, and assigned Care tasks, will be reviewed after 30 days, every 90 days and with a significant change.

Documentation of tasks performed will be audited weekly by an assigned Wellness staff member and communicated to the Director of Nursing and the Executive Director. Weekly documentation review will occur for one year post identified incident March 1, 2023, or, if documentation compliance is maintained at 95% for three consecutive months, then monitoring will be completed on a bi-weekly basis.

Further random auditing will be completed monthly by VP of Nursing and will be communicated to the property. This process has been on-going since March 2023 with no planned end date.

A285 Medications

Medication Administration will be followed step by step as stated in the policy. Medication Administration System – IA policy attached.

Each resident will receive his/her medications safely, as directed by the prescribing Licensed Healthcare Provider, in compliance with manufacturer's directions and within accepted standards of medication provision.

All medications will be provided according to the "5 Rights" (Right resident, right drug, right medications, right dose, right time). All drugs must be provided no more than 60 minutes before or 60 minutes after the scheduled time of administration. Drugs to be given 30 minutes before meals shall be provided as close to this time frame as is practical. Drugs prescribed for one resident are not used for another or for staff. The same person who prepared the dose provides it as soon as possible after preparation. Presetting of medication is not permitted. A photo of each resident is maintained on the eMAR to be used to verify resident identification. If medication is not available at a scheduled administration time the nurse will be notified immediately.

The Director of Nursing conducts ongoing monthly audits of medication administration and availability. If an error is discovered, then the Medication Error policy will be followed. The results of this audit will be reported to the Director of the Program. If any deficits are identified during the audit the Director will

notify the Regional Director of Operations and the VP of Nursing. Audits will occur for one year post identified incident March 2023 or, if compliance is maintained at 95% for three consecutive months, then monitoring will be quarterly for a year post identified incident on March 1, 2023. Audit tool attached.

A290 Tenant Documents

Routine Care/Resident Assessment Policy and Procedure followed.

When there is a change in resident condition, the Delegating Nurse will record Appropriate documentation of the changes observed including, but
not limited to:

i. Notation of objective and subjective information gathered
ii. Communication with health care provider or other health care practitioners
iii. Any new orders received as a result of the communication
iv. Action taken in response to the change in condition
v. Updated service plan
vi. Communication with Responsible Party.

The Executive Director will review daily observation notes for hospitalization or change in conditions. Then audit residents' charts to ensure nurse reviews have taken place and the above items have been completed per the policy.

A420 Nurse Review

1. Prior to the DIA Compliance visit on 3/29/23 Nurse reviews were monitored and found to be out of compliance. The nurse was hired on September 6, 2022 and was given remedial education in early December 2022, nurse reviews continued to be monitored, and disciplinary action was issued in January 2023. Nurse reviews were monitored and continued to be out of compliance. Nurse was terminated on March 1st 2023.
   The VP of Nursing assumed delegating nurse duties, including nurse reviews, until delegating nurse was hired and trained for those duties. Brenda Wilslef was hired on May 15, 2023, and has been trained in nurse review procedures and Nurse reviews have been completed every 90-days for each tenant. Brenda is registered to take the Delegating Nurse Class November 2, 2023.
2. VP of Nursing implemented Care Plan and Nurse Review on March 1st when the nurse was terminated. The VP of Nursing monitors Care Plan and Assessment compliance monthly. The outcomes of the audits are communicated to the Regional Director of Operations, the Executive Director, and the nurse monthly.
3. The Executive Director will review observations notes daily to ensure nurse reviews are being completed with each significate event. This will occur until we have obtained 95% compliance for three consecutive months and then monthly thereafter.