STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP065	A. BUILDING _____ B. WING _____	08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERSON POINT	1355 SHANNON DRIVE IOWA CITY, IA 52246

(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: 36 Number of tenants with cognitive disorder: 0 TOTAL census of Assisted Living Program: 36 The investigation of Complaint #100046-C was completed and the following regulatory insufficiency was identified:	A 000	The program will issue a 30 day written notice for all permanent transfers from the facility, both voluntary & involuntary. The program will monitor 100% of permanent transfers from facility. This procedure has already been implemented as of 10/3/2022	
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 established policy and procedure related to transfers. This pertained to 2 of 3 discharged tenants reviewed (Tenants C1 and C2). Findings follow: 1. Record review on 8-15-22 and 8-16-22 of Tenant C1's file revealed Tenant C1 was discharged on 8-26-21. Case Communication Report documentation indicated the following: -On 8-20-21 it was noted staff reported Tenant C1 had a fall on 8-19-21. Tenant C1 reached for her phone, slipped out of her chair and had no injuries. Staff attempted to get her up with the lift and the battery died. Tenant C1 was lowered back to the floor and the fire department was called to assist with getting her up.	A 150		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Victoria L Huffman — TITLE: Administrator — (X6) DATE: 11/4/22

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A 150	Continued From Page 1 -On 8-20-21 it was noted Tenant C1 pushed her pendant, requested to go to the emergency room (ER) and was transported via ambulance. The ER staff questioned what assistance Tenant C1 received at the Program. Her level of care was discussed with the ER staff and it was also reported she had three urinary tract infections (UTIs) in the past 30 to 45 days and two falls in less than one week. The advanced registered nurse practitioner in the ER said Tenant C1 likely needed a higher level of care. It was discussed that if Tenant C1 was discharged from the ER that day, the staff at the Program would meet with her on 8-23-21, regarding a transfer to a higher level of care. -On 8-23-21 it was noted after Tenant C1's fall (Thursday) a discussion occurred on 8-20-21 with a nursing supervisor regarding Tenant C1 needing a "regular two person transfer with easy lift in event of fall due to clients weight." -On 8-23-21 it was noted a message was left for Tenant C1's primary care provider (PCP) regarding to increase perineal cares to four times daily due to "unmanageable incontinence and recurrent UTIs. Also, clients need for higher level of care due to exceeding Assisted Living level of care related to not following PT/OT recommendations and unable to safely meet her needs and she is now requiring a two person assist with the easy lift due to her weight." -On 8-23-21 it was noted a telephone call was received from Tenant C1's PCP and a verbal order was received for the perineal care four times per day and the PCP "verbalized knowledge that client needs higher level of care." -On 8-24-21 it was noted a discussion occurred	A 150		

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A 150	Continued From Page 2 with Tenant C1 on 8-23-21 regarding her needing a higher level of care. It was due to not being able to safely meet her needs, she was a two person assist for transfers, that she did not independently complete, or if a fall occurred and the lift was needed. If a two person assist was not available then the fire department was called. The note indicated Tenant C1 "verbalized understanding of this increase in needs." The note indicated Tenant C1 understood that she had 30 days to find a higher level of care. Social work staff was notified to help her with the placement. -On 8-27-21 it was noted Tenant C1's PCP was notified of the transfer. Continued record review revealed Tenant C1's signed Lease Agreement and Transfer policy dated 9-27-18. The Lease Agreement indicated after the "initial term" of the agreement, the Program or tenant could end the agreement with giving a 30 day written notice (prior to the first of the next month). When interviewed Tenant C1 confirmed she did not receive a written notice to move out and an appeal process was not provided to her regarding the transfer. She said she received no assistance related to the transfer. Tenant C1 said she was told "get out" and "move out." She said her life had been negatively impacted since she transferred and moved to a higher level of care. Further record review of Tenant C1's file revealed a written 30 day notice for transfer/discharge was not provided to Tenant C1 by the Program. Tenant C1 was verbally told of the need for transfer on 8-23-21 and was discharged on 8-26-21. 2. Record review on 8-15-22 and 8-16-22 of Tenant C2's file revealed Tenant C2 was	A 150		

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A 150	Continued From Page 3 discharged on 9-24-21. Case Communication Report documentation indicated the following: -On 7-6-21 it was noted a discussion occurred with Tenant C2 regarding increased incontinence and not getting out of bed for days at a time. If Tenant C2's incontinence continued and he declined to get up, they would start discussions with his family regarding a higher level of care. -On 8-11-21 it was noted on 8-9-21 a discussion occurred with Tenant C2 regarding increased incontinence and non-compliance with cares. He was informed if it continued he would need to immediately transfer to a higher level of care. -On 8-26-21 it was noted a phone call was made to Tenant C2's legal representative regarding Tenant C2 needing a higher level of care due to incontinence and non-compliance with cares. The legal representative agreed to check other facilities. The legal representative was informed to let the Program know by end of day Monday or they would "issue official 30 day transfer notice and involve social work here to find placement." -On 9-24-21 it was noted Tenant C2's PCP was notified that Tenant C2 would be discharged to another facility that day. Continued record review revealed Tenant C2's signed Lease Agreement and Transfer policy dated 3-24-18. The Lease Agreement indicated after the "initial term" of the agreement, the Program or tenant could end the agreement with giving a 30 day written notice (prior to the first of the next month). Further record review of Tenant C2's file revealed	A 150		

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A 150	Continued From Page 4 a written 30 day notice for transfer/discharge was not provided to Tenant C2 by the Program. 3. Record review of the Program's Transfer policy and procedure indicated tenants would be assisted with transfers when they met transfer criteria. Staff would work with the tenant and tenant's legal representative (as applicable) "to ensure a safe and orderly transfer." Transfer could occur immediately or within 30 days. The date of the transfer would be in the written letter provided to the tenant regarding the transfer. Staff would explain the transfer process, including the reason for transfer, to offer assistance in finding "alternative arrangements", to explain how the next "place of residency"would be selected and to allow time for questions. The nurse would notify the tenant's PCP of the transfer and a certified copy would be sent to the Ombudsman's office. Staff helped prepare the tenant for transfer including to coordinate with the tenant and tenant's legal representative (as applicable) regarding when and how the transfer would occur. 4. When interviewed on 8-16-22 at 12:00 p.m. the Clinical Manager said Tenant C1 seemed okay with the transfer, her legal representative was not activated and she was her own decision maker. Tenant C2 did not receive a written notice regarding transfer as it was decided to move him closer to family. Any conversations regarding transfers were documented in Case Communication notes. 5. When interviewed on 8-16-22 at 12:23 p.m. the Administrator said if the Program team had a conservation with a tenant (and/or family) regarding the need for a higher level of care and they were in agreement with the transfer, they were told verbally they had 30 days. An official letter was not given if they were in agreement with	A 150		

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A 150	Continued From Page 5 the transfer. If the Program team felt they would not act promptly, then a official letter was given. She confirmed Tenant C1 and Tenant C2 did not receive a written 30 day notice regarding transfer.	A 150		