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
	16427_hfd	A. BUILDING: _____ B. WING _____	C 11/29/2022

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 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 disorder: 1 Number of tenants with cognitive disorder: 24 TOTAL Census of Assisted Living Program for People with Dementia: 25 Complaints #104754-C and #105029-C were investigated and the following regulatory insufficiencies were cited:	A 000	See Attached POC 4/14/23	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow established policies and procedures regarding completion of incident reports following medication errors. This pertained to 1 of 2 current tenants reviewed (Tenant #2). Findings follow: Record review on 11/28/22 of Tenant #2's file revealed a Provider Order Sheet dated 6/8/22 reflected an order to decrease Seroquel from 50 mg three times daily to Seroquel 50 mg twice daily. A Provider Order Sheet dated 8/3/22 reflected Seroquel 50 mg was ordered to decrease to twice daily per Tenant #2's spouse's request. It was also noted, "This order given at last visit on 6/8/22."	A 150		

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 Continued record review revealed Seroquel 50 mg three times daily reflected on the medication administration records (MARs) for June and July 2022 and documented as administered (unless refused). The August 2022 MARs reflected a change from Seroquel 50 mg three times per day to twice daily starting on 8/4/22. Further record review revealed an incident report was not completed related to the medication error that occurred for nearly two months, in which Tenant #2 received Seroquel 50 mg, three times daily and not the prescribed Seroquel 50 mg twice daily. Continued record review revealed the Program's Medication Errors Policy and Procedure indicated the person who found the error or who made the error would complete a incident report and note under type of incident that it was medication error. When interviewed on 11/28/22 at 3:09 p.m. the Executive Director confirmed all incident reports for the tenants listed above were provided.	A 150		
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	A 160		

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A 160	Continued From page 2 by: Based on interview and record review the Program failed to provide tenants with adequate and appropriate care, treatment and services. This pertained to 2 of 2 current tenants reviewed (Tenants #1 and #2) and 3 of 3 discharged tenants reviewed (Tenants C1, C2 and C3). Findings follow: 1. Record review on 11/28/22 of Tenant #1's file revealed the August 2022 task administration record (TAR) reflected omissions for the provision of cares and services including oral care, personal hygiene, COVID-19 monitoring, dressing, laundry and COVID-19 positive protocols. Continued record review revealed Observation notes dated 8/3/22 indicated Tenant #1 tested positive for COVID-19. The August 2022 TAR was updated and reflected COVID-19 positive protocols at "wakeup" 12:00 p.m., 4:00 p.m. and bedtime. The TAR included over 20 omissions related to the COVID-19 positive protocols when Tenant #1 tested positive for COVID-19. Further record review revealed the September 2022 TAR reflected omissions for the provision of cares and services including for oral care, personal hygiene, COVID-19 monitoring, dressing and laundry. The October 2022 and November 2022 TARs reflected omissions for oral care, personal hygiene, COVID-19 monitoring, dressing, laundry and incontinence product removal. 2. Record review on 11/28/22 of Tenant #2's file revealed the September 2022 to November 2022 TARs reflected omissions for the provision of	A 160		

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A 160	Continued From page 3	A 160		

cares and services including oral care, personal hygiene, dressing, COVID-19 monitoring, laundry, assistance with shaving and toileting.

3. Record review on 11/22/22 of Tenant C1's file revealed the March 2022 and April 2022 TARs reflected omissions for the provision of cares and services including for bathing, eating, oral care, personal hygiene, toileting, escorts to and from activities, laundry, COVID-19 monitoring and COVID-19 positive protocols.

Continued record review revealed Observation notes dated 3/31/22 indicated Tenant C1 tested positive for COVID-19. The March 2022 and April 2022 TAR was updated to reflect COVID-19 positive protocols at "wakeup" and "bedtime." The TAR only reflected two documented entries for the protocols, once on 4/5/22 at 2:54 p.m. for the "wakeup" timeframe and at 10:19 p.m. on 4/5/22.

4. Record review on 11/22/22 of Tenant C2's file revealed June 2021 to December 2021 TARs reflected omissions for the provision of cares and services including for bathing, dressing, personal hygiene, oral care, COVID-19 monitoring, housekeeping and laundry.

Continued record review revealed January 2022 to June 2022 TARs reflected omissions for the provision of cares and services including bathing, dressing, oral care, personal hygiene and COVID-19 monitoring.

5. Record review on 11/22/22 of Tenant C3's file revealed the March 2022 TAR reflected omissions for the provision of cares and services including bathing, dressing, oral care, personal hygiene, toileting, laundry, escorts to and from

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A 160	Continued From page 4 activities and COVID-19 monitoring. April 2022 and May 2022 TARs reflected omissions for the provision of cares and services including for dressing, oral care, personal hygiene, toileting, laundry/gather laundry and escorts to and from activities. 6. When interviewed on 11/28/22 at 3:09 p.m. the Executive Director confirmed all tasks records for the tenants listed above were provided.	A 160		
A 107	231C.5 2 Occupancy Agreement 231C.5 Written occupancy agreement required. 2. An assisted living program occupancy agreement shall clearly describe the rights and responsibilities of the tenant and the program. The occupancy agreement shall also include but is not limited to inclusion of all of the following information in the body of the agreement or in the supporting documents and attachments: a. A description of all fees, charges, and rates describing tenancy and basic services covered, and any additional and optional services and their related costs. b. (1) A statement regarding the impact of the fee structure on third-party payments, and whether third-party payments and resources are accepted by the assisted living program. (2) The occupancy agreement shall specifically include a statement regarding each of the following: (a) Whether the program requires disclosure of a tenant's personal financial information for occupancy or continued occupancy.	A 107		

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A 107	Continued From page 5 (b) The program's policy regarding the continued tenancy of a tenant following exhaustion of private resources. (c) Contact information for the department of human services and the senior health insurance information program to assist tenants in accessing third-party payment sources. c. The procedure followed for nonpayment of fees. d. Identification of the party responsible for payment of fees and identification of the tenant's legal representative, if any. e. The term of the occupancy agreement. f. A statement that the assisted living program shall notify the tenant or the tenant's legal representative, as applicable, in writing at least thirty days prior to any change being made in the occupancy agreement with the following exceptions: (1) When the tenant's health status or behavior constitutes a substantial threat to the health or safety of the tenant, other tenants, or others, including when the tenant refuses to consent to relocation. (2) When an emergency or a significant change in the tenant's condition results in the need for the provision of services that exceed the type or level of services included in the occupancy agreement and the necessary services cannot be safely provided by the assisted living program. g. A statement that all tenant information shall be maintained in a confidential manner to the extent required under state and federal law. h. Occupancy, involuntary transfer, and transfer criteria and procedures, which ensure a safe and orderly transfer. i. The internal appeals process provided relative to an involuntary transfer.	A 107		

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A 107	Continued From page 6 j. The program's policies and procedures for addressing grievances between the assisted living program and the tenants, including grievances relating to transfer and occupancy. k. A statement of the prohibition against retaliation as prescribed in section 231C.13. l. The emergency response policy. m. The staffing policy which specifies if nurse delegation will be used, and how staffing will be adapted to meet changing tenant needs. n. In dementia-specific assisted living programs, a description of the services and programming provided to meet the life skills and social activities of tenants. o. The refund policy. p. A statement regarding billing and payment procedures. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure occupancy agreements included the internal appeals process related to involuntary transfer. This pertained to 1 of 1 discharged tenant reviewed issued a written 30 day notice (Tenant C2) and potentially affected all tenants (census of 25). Findings follow: 1. Record review on 11/22/22 of Tenant C2's file revealed an admission date of 3/26/21 and a discharge date of 7/2/22. Continued record review revealed a letter dated 6/3/22 addressed to Tenant C2's legal representative. The letter indicated the Program was terminating the lease "as allowed in your occupancy agreement on page 13 which was signed on March 24, 2021." The letter indicated the Program was responsible to "comply with regulations promulgated by the Iowa Department of Inspections and Appeals and Iowa Uniform Residential Landlord and Tenant	A 107		

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A 107	Continued From page 7	A 107		

Act." The Program gave notice "pursuant to 481 Iowa Administrative Code 69.24 of its intent to discharge...thirty days from your receipt of this letter (July 3, 2022)." The letter indicated if there was disagreement with the discharge determination the Program's internal appeal process could be utilized. The letter identified to provide written notice within seven days of receipt of the letter and why there was disagreement with the transfer. Within that seven days documentation could be submitted to indicate why the discharge was not correct. The Program would review the written notice and any documentation and issue a decision in writing within five days of "submission of your written documentation." The Program could "affirm, modify or reverse its decision to discharge..."

2. Continued record review of Tenant C2's Occupancy Agreement reflected it was signed on 3/24/21. The Termination of Agreement section indicated the agreement was renewed each month unless terminated by "either party." Termination of the occupancy agreement "except otherwise provided in the Agreement, Termination of the Agreement is accomplished with a written 30-day notice ("Termination Notice") from either party." The Occupancy Agreement included a section related to Involuntary Discharge; however, the Program's internal appeals process related to involuntary transfer was not included.

3. When interviewed on 11/29/22 at 4:09 p.m. the Executive Director confirmed nothing additional found (grievance policy was provided) related to the internal appeals process for the involuntary transfer. She reached out the corporate office but had not heard back at the time of the interview.

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A 145	Continued From page 8	A 145		
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 as needed with significant change. This pertained 2 of 2 current tenants reviewed (Tenant #1 and Tenant #2) and 2 of 3 discharged tenants reviewed (Tenant C1 and C3). Findings follow: 1. When interviewed on 11/21/22 at 1:50 p.m. Staff A reported Tenant #1 refused bathing and she had not bathed her since she was admitted (two to three months ago). Tenant #1 was able to sponge bathe. Record review on 11/28/22 of Tenant #1's file revealed the July 2022 task administration record (TAR) reflected three bathing refusals. The October 2022 TAR reflected four bathing refusals and the November 2022 TAR reflected five bathing refusals.	A 145		

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A 145	Continued From page 9 Continued record review revealed the most recent evaluations were dated 7/18/22. Evaluations were not completed as needed with significant change related to Tenant #1's bathing refusals. 2. Record review on 11/28/22 of Tenant #2's file revealed incident reports indicated the following: -On 9/9/22 Tenant #2 wandered in and out of another tenant's apartment. The other tenant "got back in ....face" and then Tenant #2 grabbed the other tenant. The other tenant cried out for help and staff intervened. -On 9/12/22 Tenant #2 was laying in other tenant's bed. Staff tried to redirect Tenant #2 out of the apartment and he hit staff in the face and chest and almost ripped staff's shirt. -On 9/28/22 Tenant #2 was in another tenant's apartment. He became agitated and combative when staff approached him. He swung at staff and grabbed a staff around the neck, which left marks. Continued record review revealed Tenant #2's Observation notes documented the following: -On 10/3/22 Tenant #2 had behaviors that were not normal for him including being combative quickly with staff, he packed up belongings and had taken apart his bed frame. -On 10/28/22 Tenant #2 was removing items from his apartment all night. He was mad and "ready to fight. up all night."	A 145		

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A 145	Continued From page 10 Continued record review revealed Tenant #2's most recent evaluations completed 7/18/22. No additional evaluations were provided since the change in Tenant #2's behavior. 4. Record review on 11/22/22 of Tenant C3's file revealed Observation notes indicated the following: -On 5/10/22 at 10:06 a.m. staff found Tenant C3 on the floor by her bed. Tenant C3 was very confused and was not able to walk independently. She had two skin tears on her arm. Tenant C3's family and the Former Director of Nursing (DON) were notified. -On 5/10/22 at 10:30 a.m. the Former DON assessed Tenant C3 and noted had increased confusion and "disorganized speech beyond her normal baseline." Tenant C3 was very unstable and weak and would not bear weight on the right or left side of her body. It was noted when Tenant C3 stood up her limbs went limp. A message was left with Tenant C3's primary care provider (PCP). -On 5/10/22 at 1:15 p.m. a call back from the PCP had not been received. It was noted Tenant C3 also had visual hallucinations. Staff was transporting Tenant C3 in a wheelchair. The Former DON called the PCP again and spoke with the nurse. Verbal orders were received for an x-ray and urinalysis (UA) with culture and sensitivity. -On 5/10/22 at 2:14 p.m. it was noted staff found Tenant C3 on the floor by her bed and she was calling for help. Staff attempted to assist Tenant	A 145		

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C3 but she could not bear any weight.

-On 5/10/22 at 4:45 p.m. it was noted staff informed the Former DON that Tenant C3's speech was abnormal and she was "displaying complete right-sided weakness from the neck down." Tenant C3 was hypotensive (90/60) and all other vital signs were within normal limits (WNL). The Former DON called 911 to have Tenant C3 transported to the hospital for evaluation.

-On 5/10/22 at 8:30 p.m. the Former DON was informed Tenant C3 returned to the Program from the hospital and required extensive two assist with transfers. Tenant C3's diagnosis was an altered mental status. Staff at the hospital reported the head computed tomography (CT), UA and blood work and were all WNL

-On 5/11/22 at 7:10 a.m. it was noted staff found Tenant C3 on the floor by her bed and there was vomit next to her. As needed medications were given including, Zofran for nausea.

-On 5/11/22 at 10:30 a.m. the Former DON spoke with the PCP on Tenant C3's condition, which included a two person assist with transfers, extreme confusion, disorganized speech and the use of a wheelchair. It was noted Tenant C3 had been out with family on 5/8/22 and returned with refills for supplements. The PCP gave an order to hold supplements due to possible adverse reaction.

-On 5/11/22 at 3:15 p.m. staff assisted Tenant C3 back to her apartment. Tenant C3 refused to lay down and staff assisted her to sit up on the side of her bed. Staff left the apartment and heard a noise and returned and Tenant C3 had fallen off

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the side of the her bed. Tenant C3 sustained a cut to her head and a bandage was applied.

-On 5/11/22 at 11:52 p.m. staff found Tenant C3 on the floor in her apartment. She had been unable to walk or bear weight that evening. Due to her confusion, Tenant C3 was one to one most of the evening. A small cut was found on her head and gauze and a bandage was applied. The Former DON was notified and it was determined to send Tenant C3 to the hospital. Tenant C3 was transported via ambulance to the hospital.

-On 5/12/22 at 12:15 p.m. the Former DON spoke with a nurse at the hospital and a second head CT was completed and showed and an "infarct was found." Tenant C3 was admitted to the hospital.

-On 5/17/22 Tenant C3 was discharged from the hospital to a skilled nursing facility.

-On 5/29/22 it was unlikely Tenant C3 would return after diagnosis of cerebrovascular accident on 5/12/22.

-On 7/29/22 Tenant C3 was discharged from the system.

Continued record review revealed evaluations were not completed as needed when Tenant C3 experienced five falls including one with vomit found next to her. Tenant C3 experienced a significant change in condition including being unable to bear weight, requiring the assistance of two people for transfers, using a wheelchair, disorganized speech, increased confusion and limpness noted in her limbs and staff used one to one supervision for her. The evaluations were

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A 145	Continued From page 13 not completed as needed related to her change of condition. 5. When interviewed on 11/28/22 at 3:09 p.m. the Executive Director confirmed all evaluations the tenants listed above were provided.	A 145		
A 215	481-69.24(1)a Involuntary Transfer from Program 69.24(1) Program initiation of transfer. If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply: a. The program shall notify the tenant or tenant's legal representative, in accordance with the occupancy agreement, of the need to transfer the tenant and of the reason for the transfer and shall include the contact information for the office of long-term care ombudsman. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to notify the tenant or tenant's legal representative of the reason for the transfer. This pertained to 1 of 1 discharged tenant reviewed that received a 30 day notice for transfer (Tenant C2). Findings follow: 1. Record review on 11/22/22 of Tenant C2's file revealed an admission date of 3/26/21 and a discharge date of 7/2/22. Continued record review revealed a letter dated 6/3/22 addressed to Tenant C2's legal representative. The letter	A 215		

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A 215	Continued From page 14	A 215		

indicated the Program was terminating the lease "as allowed in your occupancy agreement on page 13 which was signed on March 24, 2021." The letter indicated the Program was responsible to "comply with regulations promulgated by the Iowa Department of Inspections and Appeals and Iowa Uniform Residential Landlord and Tenant Act." The Program gave notice "pursuant to 481 Iowa Administrative Code 69.24 of its intent to discharge...thirty days from your receipt of this letter (July 3, 2022)." The letter indicated if there was disagreement with the discharge determination the Program's internal appeal process could be utilized. The contact information for the State Long Term Care Ombudsman was also provided in letter. The letter was sent to Tenant C2's legal representative, Tenant C2's primary care provider and the Office of State Long Term Care Ombudsman via certified mail.

2. Continued record review of the Occupancy Agreement reflected it was signed on 3/24/21. The Termination of Agreement section indicated the agreement was renewed each month unless terminated by "either party." Termination of the occupancy agreement "except otherwise provided in the Agreement, Termination of the Agreement is accomplished with a written 30-day notice ("Termination Notice") from either party." The occupancy agreement indicated the following related to involuntary transfer: the Program would provide written notice for the reason for transfer, the need for discharge, if the discharge resulted from a visit completed by the Department of Inspections and Appeals (DIA) and the contact information for the Long Term Care Ombudsman. The Program would initiate procedures that ensured a safe and orderly transfer if the tenant met one or more of the

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A 215	Continued From page 15 discharge criteria. Further record review revealed the letter issued to Tenant C2's legal representative dated 6/3/22 did not provide the reason for Tenant C2's discharge from the Program. 3. When interviewed on 11/28/22 at 3:09 p.m. and 11/29/22 at 1:06 p.m. the Executive Director said the Program exercised the Tenant Landlord Act related to Tenant C2's transfer. The Program could meet Tenant C2's needs; however, could not meet the needs of Tenant C2's legal representative. She said at a meeting held on 6/29/22 the notice was verbally rescinded. She said the letter indicated regulations from DIA and Uniform Residential Landlord and Tenant Act and there was nothing additional was indicated.	A 215		
A 360	481-69.26(3) 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans within 30 days of tenant occupancy, as needed and at least annually. This pertained to 2 of 2 current tenants reviewed (Tenants #1 and #2) and 2 of 3 discharged tenants reviewed (Tenants C2 and C3). Findings follow:	A 360		

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A 360	Continued From page 16 1. Record review on 11/28/22 of Tenant #1's file revealed an admission date of 7/18/22. The most recent service plan provided was dated 7/18/22 (initial service plan). A service plan was not developed for Tenant #1 within 30 days of taking occupancy. When interviewed on 11/21/22 at 1:50 p.m. Staff A reported Tenant #1 refused bathing and she had not bathed her since she was admitted (two to three months ago). Tenant #1 was able to sponge bathe. Continued record review revealed the July 2022 task administration record (TAR) reflected three bathing refusals. The October 2022 TAR reflected four bathing refusals and the November 2022 TAR reflected 5 bathing refusals. Further record review revealed Tenant #1's service plan not updated since admission on 7/18/22. The service plan failed to reflect assistance with bathing or refusals with bathing and interventions. 2. Record review on 11/28/22 of Tenant #2's file revealed incident reports indicated the following: -On 9/9/22 Tenant #2 wandered in and out of another tenant's apartment. The other tenant "got back in ....face" and then Tenant #2 grabbed the other tenant. The other tenant cried out for help and staff intervened. -On 9/12/22 Tenant #2 was laying in other tenant's bed. Staff tried to redirect Tenant #2 out of the apartment and he hit staff in the face and chest and almost ripped staff's shirt.	A 360		

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A 360	Continued From page 17 -On 9/28/22 Tenant #2 was in another tenant's apartment. He became agitated and combative when staff approached him. He swung at staff and grabbed a staff around the neck, which left marks. Continued record review revealed Observation notes indicated the following: -On 10/3/22 Tenant #2 had behaviors that were not normal for him including being combative quickly with staff, he packed up belongings and had taken apart his bed frame. -On 10/28/22 Tenant #2 removed items from his apartment all night. He was mad and "ready to fight. up all night." Further record review revealed the service plan developed on 7/18/22 and signed on 10/5/22 reflected Tenant #2 would bang or kick the doors when agitated or exit seeking. The service plan reflected Tenant #2 had a history of becoming agitated; however, did not address the behaviors as noted above. 3. Record review on 11/22/22 of Tenant C2's file revealed Tenant C2 was discharged on 7/2/22. The most recent signed service plan was dated 4/23/21. A service plan was provided with a 12/29/21 completion date; however, the service plan was not signed by the healthcare professional or tenant. An annual signed service plan was not developed for Tenant C2. 4. Record review on 11/22/22 of Tenant C3's file revealed Tenant C3 was admitted on 7/2/21 and	A 360		

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an initial service plan was developed dated 6/30/21. A service plan was not developed for Tenant C3 within 30 days of taking occupancy.

Continued record review revealed Observation notes indicated the following:

-On 5/10/22 at 10:06 a.m. staff found Tenant C3 on the floor by her bed. Tenant C3 was very confused and was not able to walk independently. She had two skin tears on her arm. Tenant C3's family and the Former Director of Nursing (DON) were notified.

-On 5/10/22 at 10:30 a.m. it was noted the Former DON assessed Tenant C3 and she had increased confusion and "disorganized speech beyond her normal baseline." Tenant C3 was very unstable and weak and would not bear weight on the right or left side of her body. It was noted when Tenant C3 stood up her limbs went limp. A message was left with Tenant C3's primary care provider (PCP).

-On 5/10/22 at 1:15 p.m. a call back from the PCP had not been received. It was noted Tenant C3 also had visual hallucinations. Staff was transporting Tenant C3 in a wheelchair. The Former DON called the PCP again and spoke with the nurse. Verbal orders were received for an x-ray and urinalysis (UA) with culture and sensitivity.

-On 5/10/22 at 2:14 p.m. staff found Tenant C3 on the floor by her bed and she was calling for help. Staff attempted to assist Tenant C3 but she could not bear any weight.

-On 5/10/22 at 4:45 p.m. staff informed the Former DON that Tenant C3's speech was

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abnormal and she was "displaying complete right-sided weakness from the neck down." Tenant C3 was hypotensive (90/60) and all other vital signs were within normal limits (WNL). The Former DON called 911 to have Tenant C3 transported to the hospital for evaluation.

-On 5/10/22 at 8:30 p.m. the Former DON was informed Tenant C3 returned to the Program from the hospital and required extensive two assist with transfers. Tenant C3's diagnosis was an altered mental status. Staff at the hospital reported the head computed tomography (CT), UA and blood work and were all WNL

-On 5/11/22 at 7:10 a.m. staff found Tenant C3 on the floor by her bed and there was vomit next to her. As needed medications were given including, Zofran for nausea.

-On 5/11/22 at 10:30 a.m. the Former DON spoke with the PCP on Tenant C3's condition, which included a two person assist with transfers, extreme confusion, disorganized speech and the use of a wheelchair. It was noted Tenant C3 had been out with family on 5/8/22 and returned with refills for supplements. The PCP gave an order to hold supplements due to possible adverse reaction.

-On 5/11/22 at 3:15 p.m. staff assisted Tenant C3 back to her apartment. Tenant C3 refused to lay down and staff assisted her to sit up on the side of her bed. Staff left the apartment and heard a noise and returned and Tenant C3 had fallen off the side of the her bed. Tenant C3 sustained a cut to her head and a bandage was applied.

-On 5/11/22 at 11:52 p.m. staff found Tenant C3 on the floor in her apartment. She had been

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A 360	Continued From page 20	A 360		

unable to walk or bear weight that evening. Due to her confusion, Tenant C3 was one to one most of the evening. A small cut was found on her head and gauze and a bandage was applied. The Former DON was notified and it was determined to send Tenant C3 to the hospital. Tenant C3 was transported via ambulance to the hospital.

-On 5/12/22 at 12:15 p.m. the Former DON spoke with a nurse at the hospital and a second head CT was completed and showed and an "infarct was found." Tenant C3 was admitted to the hospital.

-On 5/17/22 Tenant C3 was discharged from the hospital to a skilled nursing facility.

-On 5/29/22 it was unlikely Tenant C3 would return after diagnosis of cerebrovascular accident on 5/12/22.

-On 7/29/22 Tenant C3 was discharged from the system.

Further record review revealed the service plan was not updated on 5/10/22 and 5/11/22 when Tenant C3 experienced five falls including one with vomit found next to her. She also had a significant change in her condition including being unable to bear weight, required the assistance of two people for transfers, used a wheelchair, had disorganized speech, had increased confusion and limpness noted in her limbs and staff used one to one supervision for her. The service plan was not updated as needed and did not reflect Tenant C3's service needs as it related to her change of condition.

6. When interviewed on 11/28/22 at 3:09 p.m. the

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A 360	Continued From page 21 Executive Director confirmed the most recent service plans for the tenants listed above were provided.	A 360		
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 nurse reviews every 90 days. This pertained to 2 of 2 current tenant reviewed (Tenants #1 and #2) and 3 of 3 discharged tenants reviewed (Tenants C1, C2 and C3). Findings follow: 1. Record review on 11/28/22 of Tenant #1's file revealed an admission date of 7/18/22. Observation notes for Tenant #1 revealed a nurse review was last completed on 8/18/22 and it was for a change of condition and 30 day review. Review of Tenant #1's file did not indicate a 90 day nurse review was completed. 2. Record review on 11/28/22 of Tenant #2's file revealed Observation notes for Tenant #2	A 430		

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A 430	Continued From page 22 revealed a 90 day nurse review was last completed on 7/18/22. Review of Tenant #2's file indicated a 90 day nurse review was not completed when due, 90 days after the 7/18/22 review. 3. Record review on 11/22/22 of Tenant C1's file revealed Tenant C1 was discharged on 4/26/22. Observation notes for Tenant C1 revealed a 90 day nurse review was last completed on 12/7/21. Review of Tenant C1's file indicated a 90 day nurse review was not completed when due, 90 days after the 12/7/21 review. 4. Record review on 11/22/22 of Tenant C2's file revealed Tenant C2 was discharged on 7/2/22. Observation notes for Tenant C2 revealed a 90 day nurse review was last completed on 10/19/21. Review of Tenant C2's file indicated a 90 day nurse review was as not completed when due, 90 days after the 10/19/21 review. 5. Record review on 11/22/22 of Tenant C3's file revealed Tenant C3 was discharged on 7/29/22. Observation notes for Tenant C3 revealed a 90 day nurse review was last completed on 10/19/21. Review of Tenant C3's file indicated a 90 day nurse review was as not completed when due, 90 days after the 10/19/21 review. 6. When interviewed on 11/28/22 at 3:09 p.m. the Executive Director confirmed all 90 day reviews for the tenants listed above were provided.	A 430		
A 530	481-69.29(4) Staffing 481-69.29(231C) Staffing. 69.29(4) A dementia-specific assisted living	A 530		

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A 530	Continued From page 23 program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans. A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to check on tenants in accordance with the tenants' service plan. This pertained to 2 of 2 current tenants reviewed (Tenants #1 and #2) and 3 of 3 discharged tenants reviewed (Tenants C1, C2 and C3). Findings follow: 1. Record review on 11/28/22 of Tenant #1's file revealed the service plan dated 7/18/22 reflected safety checks were scheduled once per night at 12:00 a.m. Continued record review revealed the following: The July 2022 Task Administration Record (TAR) reflected 3 omissions of the safety checks from 7/18/22 to 7/31/22. The August 2022 TAR reflected 14 omissions of the safety checks scheduled at 12:00 a.m.	A 530		

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A 530	Continued From page 24 The September 2022 TAR reflected 13 omissions of the safety checks scheduled at 12:00 a.m. The October 2022 TAR reflected 15 omissions of the safety checks scheduled at 12:00 a.m. The November 2022 TAR reflected 8 omissions of the safety checks scheduled at 12:00 a.m. 2. Record review on 11/28/22 of Tenant #2's file revealed the service plan dated 7/18/22 and (signed on 10/5/22) reflected safety checks were scheduled twice per night at 1:00 a.m. and 4:00 a.m. Continued record review revealed the following: The September 2022 TAR reflected over 25 omissions of the safety checks scheduled at 1:00 a.m. and 4:00 a.m. The October 2022 TAR reflected over 30 omissions of the safety checks scheduled at 1:00 a.m. and 4:00 a.m. The November 2022 TAR reflected over 15 omission of the safety checks scheduled at 1:00 a.m. and 4:00 a.m. 3. Record review on 11/22/22 of Tenant C1's file revealed Observation Notes indicated the following: -On 4/6/22 the nurse was made aware upon entering her apartment Tenant C1 was laying in bed. Staff attempted to prompt Tenant C1 to get out of bed, Tenant C1 attempted to sit up and screamed "very loudly." Tenant C1 would not sit	A 530		

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up or follow prompts from staff. When staff provided hands on assistance Tenant C1 "screamed erratically and began trembling and speaking a nonsensical jumble of words." Staff called for the nurse to assess Tenant C1. The nurse completed a physical assessment for pain and she did not display any non-verbal signs of pain. Tenant C1's primary care provider was contacted and an order was received for APAP 650 milligram (mg), twice daily for discomfort. Staff and the nurse attempted to prop Tenant C1 up to eat and and Tenant C1 "continued to scream out upon the slightest movement or touch." It was determined Tenant C1 needed to be sent to the hospital for evaluation. An ambulance was called and Tenant C1 was transported to the hospital via ambulance.

-On 4/6/22 a nurse from the hospital called and said Tenant C1 would be admitted due to a pelvic fracture. It was discussed with Tenant C1's family that staff was not aware of any injury or fall that occurred. It was determined Tenant C1 might have fallen or injured herself when independently walking or transferring in her apartment.

Continued record review revealed a Service Plan Task record indicated safety checks were scheduled twice per night at 1:00 a.m. and 4:00 a.m.

Further record review revealed the April 2022 TAR indicated from 4/1/22 to 4/5/22 only one safety check was documented and it was documented on 4/5/22 at 2:54 p.m. (not at the scheduled time). There were no safety checks documented at 1:00 a.m. and 4:00 a.m. as scheduled the night prior to Tenant C1's pelvic fracture, hospitalization and discharge to a higher level of care.

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COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

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A 530	Continued From page 26 4. Record review on 11/22/22 of Tenant C2's file revealed the service plan reflected Tenant C2 safety checks were scheduled twice per night at 1:00 a.m. and 4:00 a.m. Continued record review indicated the following: The April 2022 TAR had over 30 omissions of the safety checks scheduled at 1:00 a.m. and 4:00 a.m. The May 2022 TAR had 7 omissions of the safety check scheduled at 1:00 a.m. and 4:00 a.m. The June 2022 TAR had over 25 omissions of the safety checks scheduled at 1:00 and 4:00 a.m. 5. Record review on 11/22/22 of Tenant C3's file revealed the service plan reflected safety checks were scheduled at 12:00 a.m. and 3:00 a.m. Continued record review revealed the following: The March 2022 TAR reflected 20 omissions of safety checks at 12:00 a.m. and 3:00 a.m. The April 2022 TAR reflected over 30 omissions of the safety checks scheduled at 1:00 a.m. and 4:00 a.m. The May 2022 TAR (5/1/22 to 5/11/22) reflected 4 omissions of the safety checks scheduled at 1:00 a.m. and 4:00 a.m. 6. When interviewed on 11/28/22 at 3:09 p.m. the Executive Director confirmed all task records for the tenants listed were provided.	A 530		

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
	16427_hfd	A. BUILDING: _____ B. WING _____	C 11/29/2022

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

CountryHouse Residence

Cedar Rapids

Investigations #104754-C and #105029-C

Plan of Correction

A150

Program Policies and Procedures

1. We will provide a mandatory in service to all staff to review incident and medication error policy. This will be completed over the next 30 days (April 14th, 2023).
2. The nurse will investigate all medication errors and ensure appropriate reporting has been completed.

A160

Tenant rights

1. CountryHouse will assign an employee to review documentation prior to end of shift to ensure all documentation is complete.
2. Weekly Executive Director will monitor documentation is being completed.
3. Further random auditing will be completed monthly by Corporate Nurse and will be communicated to the property.
4. This correction will occur starting March 29, 2023.

A107
Occupancy Agreement

1. The Occupancy Agreement is being reviewed by an attorney to make updates as necessary to comply with regulations.
2. Change in Occupancy Agreement will be given to current tenants.
3. Updated Occupancy Agreement will be used with all new move-ins.
4. Correction will be made by April 14, 2023.

A145

Evaluation of tenant

1. Evaluations were monitored and found to be out of compliance. The nurse was given remedial education in December, evaluations continued to be monitored, disciplinary action was issued in January. Evaluations were monitored and continued to be out of compliance. Nurse was terminated on March 1st.
2. The VP of Nursing will assume delegating nurse duties including evaluation of tenants until delegating nurse is hired and trained for those duties. Evaluation will be completed prior to admission, within 30 days after admission and with a significant change but not less than annually.
3. VP of Nursing implemented this on March 1st when the nurse was terminated. VP of Nursing will complete monthly audits and communicate to the community.

A215

Involuntary Transfer from the program

1. The Occupancy Agreement is being reviewed by an attorney to make updates as necessary to comply with regulations.
2. Change in Occupancy Agreement will be given to current tenants.
3. Updated Occupancy Agreement will be used with all new move-ins.
4. Correction will be made by April 14, 2023.

A360

Service Plans

1. Service Plans reviews were monitored and found to be out of compliance. The nurse was given remedial education in December, nurse reviews continued to be monitored, disciplinary action was issued in January. Nurse reviews were monitored and continued to be out of compliance. Nurse was terminated on March 1st.
2. For every evaluation completed by a delegated nurse a service plan will be reviewed and updated by that nurse.
3. Evaluation will be completed prior to admission, within 30 days after admission and with a significant change but not less than annually.
4. All Service Plans will be reviewed and updated at necessary by April 14, 2023.

A430

Nurse review

1. Nurse reviews were monitored and found to be out of compliance. The nurse was given remedial education in December, nurse reviews continued to be monitored, disciplinary action was issued in January. Nurse reviews were monitored and continued to be out of compliance. Nurse was terminated on March 1st.

2. The VP of Nursing will assume delegating nurse duties including nurse reviews until delegating nurse is hired and trained for those duties. Nurse reviews will be completed every 90-days for each tenant.
3. VP of Nursing implemented this on March 1st when the nurse was terminated. The VP of Nursing will monitor compliance quarterly.

A530

Staffing

1. The program will maintain adequate staff to ensure care is provided as directed in the service plan.
2. CountryHouse will assign an employee to review documentation prior to end of shift to ensure all documentation is complete per service plan. Weekly Executive Director will monitor documentation is being completed. Further random auditing will be completed monthly by VP of Nursing and will be communicated to the property.
3. This correction will occur immediately as March 29, 2023.

Abby Reed Executive Director
3/28/23