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 05/07/2025

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 visit. Number of tenants without cognitive impairment: 5 Number of tenants with cognitive impairment: 24 Total census: 29 No regulatory insufficiencies were cited during the investigations of Compliants #128147-C and #128197-C or abuse investigations #127240-M, #127205-A and #127775-A The following regulatory insufficiencies were cited during the investigations of Complaints #127773-C and #128156-C.	A 000	See attached POC 6/6/25	
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 ensure appropriate medical cares and treatments were being completed for 2 of 6 tenants reviewed (Tenant #5 and Tenant #6). Findings follow:	A 160		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 160	Continued From page 1 1. On 5/07/25 record review revealed Tenant #5's observation notes indicated she was hospitalized on 2/10/25 due to hypoxia and Influenza A. Tenant #5 returned to the program on 2/20/25 with a note by Registered Nurse (RN) B indicating the tenant needed oxygen while doing activities and sleeping, 1 liter per nasal canula. An observation note by RN B on 2/28/25 indicated Tenant #5 would see her primary care provider that day and the program needed more clear instructions due to the tenant having low oxygen levels in the evenings, but no additional information was noted. An observation note by a staff member on 3/23/25 indicated Tenant #5's oxygen level was low and the nurse was aware. Tenant #5's change of condition care plan dated 2/20/25 indicated she would receive oxygen per doctor orders. The care plan noted under oxygen"directions" Tenant #5 received 1 liter per nasal canula and under "provider interventions" she received 3 liters per nasal canula, which was conflicting information. The care plan provided no additional information regarding when the oxygen should be used. Review of medication administration records (MARs) for March, April and May 2025 revealed no information regarding oxygen use. A physician's order for oxygen use could not be located. Tenant #5 was 82 years old, with a diagnosis including dementia, generalized anxiety disorder and hypertension. She had a Global Deterioration Scale (GDS) score of 6, which indicated severe cognitive decline. During an interview on 5/07/25 at 3:30 p.m. RN A	A 160		

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A 160	Continued From page 2	A 160		

confirmed Tenant #5 returned to the program on 2/20/25 on oxygen, which was a change of condition. RN A stated she was unable to locate a doctor's order regarding use of the oxygen. The RN confirmed information regarding use of the oxygen was not on listed on Tenant #5's MARs, treatment administration records or included on staff task sheets. Staff were instructed verbally regarding Tenant #5's oxygen use.

2. During an interview on 5/05/25 at 4:30 p.m. Staff A said a pressure sore on Tenant #6's bottom had not healed in weeks.

On 5/06/25 at 3:00 p.m. Tenant #6's wife said her husband had a pressure sore on his coccyx when he moved to the program about three years ago. She indicated the sore repeatedly healed and re-opened. Tenant #6's wife said the doctor advised to keep applying ointment.

On 5/06/25 record review revealed Tenant #6 was 76 years old with a diagnosis including type 2 diabetes, obesity, anoxic brain damage, congestive heart failure and chronic kidney disease. He was not under hospice care. Tenant #6 had a GDS of 6, which indicated severe cognitive decline.

Review of Tenant #6's observation notes since February 2025 revealed only two notes regarding a sore on his bottom/coccyx area. A staff documented on 3/18/25 of an open area on right buttock cheek. There was no follow-up note in March or April regarding the open area. An observation note on 5/06/25 by RN A indicated staff had applied a Band-Aid to Tenant #6's sacral wound. She directed staff to replace the Band-Aid with a sacral border dressing. RN A noted the area appeared unchanged from last assessment

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A 160	Continued From page 3 on 5/02/25. Review of Tenant #6's care plan dated 4/28/25 indicated he had a chronic area at the top of his buttocks that opened and closed. The care plan directed staff to apply barrier ointment each time he was toileted. Review of Tenant #6's March and April MAR revealed no information/order for an ointment to be applied to wound on coccyx/buttocks. No physician's order for treatment for the wound could be located. During an interview on 5/06/25 at 3:45 p.m. RN A confirmed there was no physician's order or any information on his MARs regarding Tenant #6's pressure sore on his coccyx. She said the sore was sometimes healed and sometimes open. RN A was not aware of staff applying an ointment but stated Tenant #6's wife visited him daily, so she might apply an ointment to the wound. RN A said she instructed staff to apply an adhesive border wound dressing, but this was not documented anywhere. She said she's never seen a doctor's order regarding treatment for the coccyx sore. During a follow-up interview on 5/06/25 at 4:10 p.m. RN A verified she should have documented a note/assessment regarding the sore noted by staff on 3/18/25. RN A said she thought she assessed the area at the time and saw no wound on right buttock, but the coccyx wound was open. RN A stated the coccyx wound opened up again last week and she advised staff to apply the border bandages, but failed to document this. The physician was not notified and did not order the border wound dressing.	A 160		

ok
7/1/25

CountryHouse Residence

Cedar Rapids

Plan of Correction 4.28 – 5.07.25 investigation

Correction date: 6.06.2025

A 160

481-67 .3(2) Tenant rights. All tenants have the right to receive care, treatment and services which are adequate and appropriate.

Program failed to confirm and administer Oxygen per physician orders for a tenant returning from a hospital stay.

Since November 13th several RN's have filled in at the community, including temporary agency nurses, until hiring a full-time RN. The new Director of Nursing has been hired and began employment on March 4th. The physician order for the administration of the oxygen was miss placed and found prior to DIAL surveyor completing her investigation.

Immediately upon discovery of the missing order on May 7, 2025, the RN secured a copy of the order and clarified the MAR for accuracy.

Medications will be administered as prescribed by the tenant's physician. Oxygen is a medication and will be placed on the MAR giving full directions for administration following tenant physician orders, and documentation confirming accurate administration completed.

The Director of Nursing or designee will conduct weekly random oxygen audits for three months, then monthly for 6 months. Finding will be reported to the VP of Nursing and Executive Director.

All corrective actions were completed on May 7, 2025, and ongoing weekly Oxygen audits will occur for three months, then monthly for 6 months.

The Registered Nurse will assess and document changes in the health status of the tenants. After a significant change in the tenant's condition the Registered Nurse will make appropriate referrals (e.g. update the tenant's physician) and will ensure that the prescription/physician orders are current and that the prescriptions are administered consistent with the tenant's physician orders. An individualized service plan will be developed to address identified needs and interventions per resident preference If a significant change relates to a recurring or chronic condition, it will be addressed on the Service Plan as such.

Documentation of health status changes will be reviewed by the Director of Nursing and Executive Director during their weekly one on one meetings.