STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD440 HFD	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNITY M	765 BOYSON ROAD NE CEDAR RAPIDS, IA 52402

(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: 0 Number of tenants with cognitive disorder: 7 TOTAL Census of Assisted Living Program for People with Dementia: 7 Complaint #107143-C was investigated and the following regulatory insufficiencies were cited:	A 000	See Attached POC 6/3/23	
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 implement established policies and procedures, including for falls with head injury and medication management. This pertained to 1 of 2 current tenants reviewed (Tenant #1) and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow: 1. Record review on 2/15/23 of Tenant #1's file revealed the service plan dated 1/19/23 indicated staff administered Tenant #1's medications. Continued record review revealed Incident Report Forms indicated the following: -On 1/29/23 it was noted staff brought two medications in a bag to another staff. The medications had been found in Tenant #1's apartment by Tenant #1's family. It was noted	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 TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD440 HFD	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNITY M	765 BOYSON ROAD NE CEDAR RAPIDS, IA 52402

(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 150	Continued From Page 1 Tenant #1's family was very upset and it was second time the family had found medications in her apartment. Staff looked the up the medications and one was Seroquel 25 milligram (mg), a small brown pill and the other medication was trazodone 125 mg, a large white pill. It was noted the medications were "Consistent" with Tenant #1's bedtime medications. -On 2/5/23 it was noted Tenant #1's family found medications on top of her tissue box from 2/4/23 (second shift medications). The report identified the medications a trazodone 125 mg, one tablet, and atorvastatin 40 mg, one tablet. -On 2/8/23 it was noted Tenant #1's family found one of Tenant #1's medications in her apartment and brought it to staff. All three Incident Report Forms noted above indicated the incidents were medication errors. Further record review revealed Tenant #1 did not receive her medications as prescribed three times from 1/29/23 to 2/8/23 as evidenced by multiple medications being found in her apartment by her family. Medications were not administered per the Program's policy and procedure related to medication management. Record review of the Program's policy and procedure related to medication management indicated medications would be administered as prescribed by the tenant's PCP. When interviewed on 2/16/23 at 3:22 p.m. the Executive Director said there had not been any adverse outcomes related to Tenant #1's medication errors. Staff now administered her medications by putting them in a medication cup and giving the medications to Tenant #1 with a	A 150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD440 HFD	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNITY M	765 BOYSON ROAD NE CEDAR RAPIDS, IA 52402

(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 150	Continued From Page 2 spoon, one at a time. 2. Record review on 2/15/23 of Tenant C2's file revealed the service plan was dated 10/19/22 reflected Tenant C2 had two hour safety checks. The service plan also indicated Tenant C2 had a history of falls. Tenant C2 was staged at six on the Global Deterioration Scale, which indicated severe cognitive decline. Continued record review revealed an Incident Report Form indicated on 10/21/22 at 9:50 p.m. staff found Tenant C2 on the floor, without clothing, when staff completed rounds. Tenant C2 had slipped out of his chair. Further record review revealed an Incident Report Form indicated on 10/22/22 at 2:19 a.m. vitals were obtained after a fall that occurred earlier and Tenant C2's blood pressure was 230/95 and when checked again it was 231/101. Tenant C2 was combative, shouted, cried, was shaking and lashed out. Tenant C2's spouse was called and Tenant C2 was sent out to the hospital for evaluation. Continued record review revealed Progress Notes indicated the following: -On 10/21/22 it was noted at 9:24 p.m. staff reported Tenant C2 fell tonight. Staff notified Tenant C2's spouse, who declined to take Tenant C2 out for evaluation. Staff was instructed to take Tenant C2's vital signs with safety checks and to monitor for symptoms (nausea, vomiting, dizziness, headaches, changes with vital signs, condition changes or lethargy) and report to the nurse any changes or concerns. -On 10/22/22 it was noted at 1:00 a.m. staff	A 150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD440 HFD	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNITY M	765 BOYSON ROAD NE CEDAR RAPIDS, IA 52402

(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 150	Continued From Page 3 notified the nurse on call of Tenant C2's elevated blood pressure. Staff was instructed to recheck his blood pressure and notify Tenant C2's spouse to send him out for evaluation. Staff notified the nurse at 3:00 a.m. that Tenant C2 was taken to the hospital. -On 10/22/22 it was noted Tenant C2 was admitted to the hospital and had a diagnosis of acute encephalopathy. -On 10/28/22 it was noted hospital staff reported Tenant C2 had a stroke and the plan was for long term care placement. Further record review revealed October 2022 safety checks (a check of vitals and monitoring of symptoms was to be completed with safety checks) indicated the following: -On 10/21/22 and 10/22 on third shift safety checks were documented as completed at 10:30 p.m. and 1:03 a.m. Tenant C2 was noted to be sleeping in both checks. Continued record review revealed a Nurse Review dated 10/22/22 indicated on 10/21/22 at 9:50 p.m. Tenant #1 was observed on the floor of his apartment. On 10/22/22 at approximatley 2:19 a.m. Tenant C2's blood pressure was 230/95 and Tenant C2 had become agitated and aggressive. Staff notified Tenant C2's spouse, who was agreeable to have him evaluated at the hospital. Tenant C2 was admitted for acute encephalopathy. Further record review revealed the October 2022 medication administration record (MAR) reflected to check Tenant C2's vitals with safety checks (every two hours) and monitor for symptoms (nausea, vomiting, dizziness, headaches, changes	A 150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD440 HFD	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNITY M	765 BOYSON ROAD NE CEDAR RAPIDS, IA 52402

(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 150	Continued From Page 4	A 150		

with vital signs, condition changes or lethargy) and report to the nurse any changes or concerns. It was added on the MAR on 10/21/22 at 10:00 p.m. and the first vital check was documented at 10:00 p.m. Tenant C2's blood pressure at that check was 140/77. The next check was signed off at 12:00 a.m. and Tenant C2's blood pressure was 235/95. Progress Notes, an Incident Report, safety checks, and a Nurse Review document indicated the vitals were checked at approximatley 1:00 a.m. or 2:19 a.m.; which was more than two hours from the previous documented vital signs check.

In summary, Tenant C2's file lacked documentation of neurological checks by a nurse when Tenant C2's spouse initially refused to have Tenant C2 evaluated at the hospital after an unwitnessed fall (Tenant C2 had cognitive impairment). Additionally, the check of Tenant C2's vital signs and symptoms added to the MAR was not completed at the scheduled two hour intervals as it was completed at 10:00 p.m. and then per Progress Notes, Incident Report, safety checks and a Nurse Review, was not completed and reported to the nurse until approximately 1:00 a.m. or 2:19 a.m.; which was greater than two hours from the last check of Tenant C2's vital signs. Tenant C2 was sent out to the hospital, he was admitted and had a diagnosis of acute encephalopathy. Tenant C2 had a stroke and long term care placement was needed. The Program's policy and procedure related to falls with head injuries was not followed related to Tenant C2's incident.

Record review of the Program's policy and procedure related to falls with head injury revealed any tenants that had a fall and might have hit their head on a "hard object or surface" would be assessed for head trauma. Tenants with cognitive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD440 HFD	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNITY M	765 BOYSON ROAD NE CEDAR RAPIDS, IA 52402

(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 150	Continued From Page 5 impairment that sustained an unwitnessed fall "will be treated as though they struck their head." The nurse would notified immediately of a fall or incident that included hitting their head on a "solid surface." The nurse would direct the tenant be evaluated at the hospital for possible head trauma. If the tenant or legal representative declined evaluation the nurse would provide education related to head injury. If the tenant continued to refuse, the nurse would document the tenant's refusal and notify the primary care provider (PCP). If a tenant refused medical care, a nurse would complete neurological checks. The checks would be completed by the nurse and frequency of the neurological checks would be determined by the nurse. The nurse would have non-licensed staff to report any of the following symptoms: nausea, vomiting, headache, changes in mental status, dizziness and changed in vitals or vision. When interviewed on 2/16/23 at 3:45 p.m. the Nurse Consultant confirmed neurological checks were not completed for Tenant C2 as a licensed nurse was not in the building. She told staff to monitor Tenant C2's vital signs with his safety checks.	A 150		
A 530	481-69.29(4) Staffing 69.29(4) A 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 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	A 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD440 HFD	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNITY M	765 BOYSON ROAD NE CEDAR RAPIDS, IA 52402

(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 530	Continued From Page 6 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 have staff monitor and check on tenants as indicated in the tenants' service plans. This pertained to 2 of 2 current tenants reviewed (Tenants #1 and #2) and 2 of 2 discharged tenants (Tenants C1 and C2). Findings follow: 1. Record review on 2/15/23 of Tenant #1's file revealed the service plan dated 1/19/23 reflected Tenant #1 required hourly safety checks. Continued record review of the February 2023 safety checks revealed the checks were not completed as indicated in Tenant #1's service plan. Examples included: -On 2/3/23 there were six scheduled hourly safety checks on second shift documented as completed at 8:10 p.m. -On 2/4/23 the last documented safety check was completed at 1:42 p.m. There were no safety checks documented as completed for second shift on 2/4/23. -On 2/5/23 there were five scheduled hourly safety checks on third shift documented as completed at 2:31 a.m. -On 2/8/23 all documented scheduled hourly safety checks on third shift were documented as completed at 5:24 a.m. and 5:25 a.m.	A 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD440 HFD	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNITY M	765 BOYSON ROAD NE CEDAR RAPIDS, IA 52402

(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 530	Continued From Page 7 -On 2/9/23 all documented scheduled hourly safety checks on third shift were documented as completed at 5:25 a.m. -On 2/10/23 there were six scheduled hourly safety checks on third shift documented as completed at 4:13 a.m. -On 2/10/23 there were eight scheduled hourly safety checks on second shift documented as completed at 8:47 p.m. It was noted Tenant #1 was engaged in an activity or enrichment for seven of the eight hours documented. The next check was documented on 2/11/23 at 6:56 a.m. -On 2/15/23 there were six scheduled hourly safety checks on third shift documented as completed at 3:58 a.m. 4. Record review on 2/15/23 and 2/16/23 of Tenant #2's file revealed the Task Report List reflected Tenant #2 required hourly safety checks due to a high fall risk. Continued record review revealed an Incident Report Form dated 2/11/23 at 1:45 p.m. indicated staff heard Tenant #2 yelling and responded. Tenant #2's feet were twisted (incident occurred at the recliner) and he was yelling Staff released him to the floor and called for assistance. Staff looked at his feet and got him back into the chair. Further record review of the February 2023 safety checks revealed the checks were not completed hourly, including when Tenant #2's feet twisted and he was lowered to the floor. Examples included: -On 2/4/23 there were eight scheduled hourly safety checks on first shift documented as completed at 1:33 p.m. and 1:34 p.m. There were	A 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD440 HFD	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNITY M	765 BOYSON ROAD NE CEDAR RAPIDS, IA 52402

(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 530	Continued From Page 8 no safety documented as completed for second shift. -On 2/5/23 there were five scheduled hourly safety checks on third shift documented as completed at 2:29 a.m. and 2:30 a.m. -On 2/5/23 a scheduled hourly safety check was documented at 1:01 p.m. and the next scheduled hourly safety check was documented on 2/6/23 at 6:09 a.m. There were no scheduled hourly checks documented for second or third shifts. -On 2/8/23 there were eight scheduled hourly safety checks on third shift documented as completed at 5:21 a.m. and 5:22 a.m. -On 2/9/23 there were eight scheduled hourly safety checks on third shift documented as completed at 5:24 a.m. -On 2/10/23 a scheduled hourly safety check was documented at 12:36 p.m., the next scheduled hourly safety check was documented at 7:51 p.m. All eight scheduled hourly safety checks on second shift were documented as completed between 7:51 p.m. and 8:49 p.m. The next scheduled hourly safety check was documented as completed on 2/11/23 at 6:55 a.m. -On 2/11/23 there were four scheduled hourly checks documented at 12:20 p.m., including at the last check on first shift, during the time of Tenant #2's incident on 2/11/23. 5. Record review on 2/14/23 and 2/15/23 of Tenant C1's file revealed the service plan dated 8/8/22 reflected Tenant C1 required one hour safety checks. Continued record review revealed an Incident	A 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD440 HFD	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNITY M	765 BOYSON ROAD NE CEDAR RAPIDS, IA 52402

(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 530	Continued From Page 9 Report Form indicated on 8/21/22 at 2:55 a.m. staff went to check on tenants and checked on Tenant C1 and found her on the floor. The report indicated Tenant C1 was "bleeding through her nose." Tenant C1 wanted to get down from the bed and had fallen forward face down. The report indicated Tenant C1's spouse was called but did not answer. Further record review revealed Progress Notes indicated the following: -On 8/21/22 it was noted staff notified the nurse that Tenant C1 fell from bed, had bloody nose and requested to go to the hospital. -On 8/21/22 it was noted the nurse spoke with hospital staff and Tenant C1 had a fractured left patella -On 8/25/22 it was noted Tenant C1 was discharged from the hospital and was transferred to another memory care unit. Continued record review revealed hospital records (physical therapy note) indicated Tenant C1 sustained a fall, had a nondisplaced fracture of the left patella and a facial laceration. Further record review revealed August 2022 safety checks were not documented as completed as indicated Tenant C1's service plan, including on the date of the fall. Examples included: -On 8/20/22 on second shift scheduled hourly safety checks were documented at 2:51 p.m. (x2), 4:13 p.m., 5:28 p.m. (x2), 7:55 p.m., 8:34 p.m., and 9:35 p.m. -On 8/20/22 and 8/21/22 on third shift scheduled hourly safety checks were documented at 11:37	A 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD440 HFD	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNITY M	765 BOYSON ROAD NE CEDAR RAPIDS, IA 52402

(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 530	Continued From Page 10 p.m. (x2) and three scheduled hourly safety checks were documented as completed at 1:44 a.m. It was noted Tenant C1 was sleeping in all of the checks documented at 11:37 p.m. at 1:44 a.m. The next two safety checks were documented at 4:26 a.m. and it was noted Tenant C1 was not in the building. Staff D documented she completed the checks on third shift on 8/20/22 to 8/21/22. An attempt to interview Staff D was completed but was unsuccessful. Safety checks as indicated in Tenant C1's service plan, were not completed at the scheduled hourly intervals, including when Tenant C1 fell, sustained an injury and was transferred to a hospital. 6. Record review on 2/15/23 of Tenant C2's file revealed the service plan was dated 10/19/22 reflected Tenant C2 had two hour safety checks. Continued record review revealed an Incident Report Form indicated on 10/21/22 at 9:50 p.m. staff found Tenant C2 on the floor, without clothing, when staff completed rounds. Tenant C2 had slipped out of his chair. Further record review revealed an Incident Report Form indicated on 10/22/22 at 2:19 a.m. vitals were obtained after a fall that occurred earlier and Tenant C2's blood pressure was 230/95 and when checked again it was 231/101. Tenant C2 was combative, shouted, cried, was shaking and lashed out. Tenant C2's spouse was called and Tenant C2 was sent to the hospital for evaluation. Continued record review revealed Progress Notes indicated the following: -On 10/21/22 it was noted at 9:24 p.m. staff reported Tenant C2 fell tonight. Staff notified Tenant C2's spouse who declined to take him to	A 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD440 HFD	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNITY M	765 BOYSON ROAD NE CEDAR RAPIDS, IA 52402

(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 530	Continued From Page 11 the hospital for evaluation. Staff was instructed to take Tenant C2's vital signs with safety checks and monitor for symptoms (nausea, vomiting, dizziness, headaches, changes with vital signs, condition changes or lethargy) and report to the nurse any changes or concerns. -On 10/22/22 it was noted at 1:00 a.m. staff notified the nurse on call of Tenant C2's elevated blood pressure. Staff was instructed to recheck his blood pressure and notify Tenant C2's spouse to request to send him to the hospital for evaluation. Staff notified the nurse at 3:00 a.m. that he was taken out to the hospital. -On 10/22/22 it was noted Tenant C2 was admitted to the hospital and an diagnosis of acute encephalopathy. -On 10/28/22 it was noted hospital staff reported Tenant C2 had a stroke and the plan was for long term care placement. Further record review revealed October 2022 safety checks were not documented as completed as indicated Tenant C2's service plan, including on the date of the fall. Examples included: -On 10/21/22 there were three scheduled safety checks on third shift documented as completed at 4:45 a.m. -On 10/21/22 on first shift safety checks were documented as completed at 6:29 a.m., 9:56 a.m. and 12:23 p.m. (x2). -On 10/21/22 on second shift safety checks were documented as completed at 2:21 p.m., 4:38 p.m., 6:34 p.m. and 9:00 p.m. -On 10/21/22 and 10/22 on third shift safety	A 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD440 HFD	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNITY M	765 BOYSON ROAD NE CEDAR RAPIDS, IA 52402

(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 530	Continued From Page 12 checks were documented as completed at 10:30 p.m. and 1:03 a.m. Tenant C2 was noted to be sleeping in both checks. Safety checks as indicated in Tenant C2's service plan, were not completed at the scheduled two hour intervals, including when Tenant C2 had elevated blood pressure (post fall) and was sent to the hospital where he was diagnosed with acute encephalopathy. 7. When interviewed on 2/16/23 at 3:22 p.m. the Executive Director confirmed all documentaiton of safety checks for the tenants listed above were provided. She said the expectation regarding checks was that they were documented at the time of completion.	A 530		

Boyson Heights
A Senior Living Community

Department of Inspections and Appeals
Attn: Catie Campbell
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Campbell:

On behalf of Boyson Heights Assisted Living in Cedar Rapids, Iowa, I respectfully submit our Plan of Correction for your approval. This response is specific to complaint #110172-C report for the onsite visit 2/14/2023-2/16/2023. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusions set forth in the statement of insufficiencies. The Plan of Correction is executed solely because it is required by the provisions of Iowa Law.

Service Plans:

1. Elements detailing how the program will correct each regulatory insufficiency.
    - Tenant #1 service plan was updated on 3/3/2023 to reflect history of refusal of medications.
    - The service plan for tenant #2 was updated on 05/09/2023 to reflect a history of weight loss.
2. Measures taken to ensure the problem does not recur.
    - The Director of Nursing and Nurse Designee will be re-educated regarding Service Plans and the regulatory requirements contained in Chapter 69.26.
    - Service plans will be developed for each tenant and will be based on the evaluation, individualized for each tenant, updated whenever changes are needed and at least annually in accordance with regulation.
3. How the Program plans to monitor performance to ensure compliance.
    - The Director of Nursing and/or Nurse Designee will review the service plans for all tenants receiving personal or health-related cares, at least quarterly and when changes are needed.
    - The Director of Nursing and/or Nurse Designee will review the service plans of all tenants at least annually and when changes are needed.
4. The date by which the regulatory insufficiency will be corrected.
    - The regulatory insufficiency will be corrected on or before June 3rd, 2023.

If you have any questions regarding this plan of correction, please contact me at (319) 775-4524.

Respectfully submitted,
Katie Bruce
Executive Director