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
	S0440	A. BUILDING: _____ B. WING _____	C 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNI	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. Tenants without cognitive impairment: 1 Tenants with cognitive impairment: 10 Total census: 11 The following regulatory insufficiencies were cited related to the investigation of Complaint #129709-C.	A 000	See attached POC 12/30/2025	
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 interviews and record review the Program failed to follow established policy and procedure related to incident reports. This pertained to 1 of 1 discharged tenant reviewed with falls (Tenant C2). Finding follows: Record review on 9/29/25 to 10/01/25 of Tenant C2's file revealed a Staff Communication Report dated 12/20/24 at 9:54 a.m. indicated staff reported to a nurse in person that Tenant C2's left great toe was swollen and bruised. It was indicated as new related to pain. At 10:51 a.m., the report noted acetaminophen administered. Continued record review revealed a Tenant Health Review dated 12/20/24 indicated a nurse was notified that Tenant C2's left great toe was	A 150		

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A 150	Continued From page 1	A 150		

swollen and bruised. When assessed by a nurse it was noted the left great toe and forefoot area was swollen with purple bruising to the anterior and posterior of the toe. The review noted Tenant C2 ambulated per her usual but had some pain. The nurse spoke with staff to determine the cause of her injury. Staff that worked second shift on 12/19/24 said she fell at about 8:45 p.m. and was ambulating without her walker. No injuries or pain were noted at the time of the fall; staff assisted her up off of the floor and she ambulated per usual. Staff was educated to call the nurse on-call and fill out incident reports for all falls. Tenant C2's primary care provider (PCP) was notified of the fall and provided an order for Tylenol 1000 milligram (mg), three times daily for seven days. Tenant C2's family was notified and declined to take her to urgent care at that time. It noted her history of falls. The review noted the effective date of 12/20/24 and was signed on 12/23/24.

Further record review revealed an Incident Report Form dated 12/19/24 (not completed at time or day of the fall) indicated at 8:45 p.m. staff went to another tenant's room to assist with the bathroom. She came back and found Tenant C2 sitting on the floor. Staff made sure Tenant C2 was okay before helping her up and she seemed to be fine. The incident report failed to record vital signs. The incident was not reported to a nurse until 12/20/24 at 9:30 a.m., to the PCP on 12/20/24 at 10:00 a.m. and to family on 12/20/24 at 10:10 a.m. The nurse signed the report on 12/23/24.

Record review of the Program's Accident, Incident, and Medication Error Reporting policy and procedure dated 12/23, indicated an incident report form would be used to document any

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A 150	Continued From page 2 accidents, incident and or medication errors. Any incidents would be documented in detail on the incident report form. The staff in charge at the time of the incident completed and signed the form. When interviewed on 10/01/25 at the Executive Director at 2:20 p.m. confirmed an incident report should be completed within the shift time period then given to the nurse. When interviewed on 10/01/25 at 1:37 p.m. the Chief Nursing Officer and Partner with the management company, confirmed incident reports should be completed at the time of the incident.	A 150		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer tenants' medications as ordered for pain control after a fall and end of life. This pertained to 1 of 1 discharged tenant reviewed who received hospice	A 285		

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A 285	Continued From page 3 services (Tenant C2). Finding follows: 1. Record review from 9/29/25 to 10/01/25 of Tenant C2's file revealed the following medication changes: a. On 12/20/24, received a verbal order from the primary care provider (PCP) for acetaminophen oral tablet 500 milligram (mg), two tablets by mouth three times per day for seven days. The PCP signed the order on 12/31/24. b. December 2024 medication administration records (MARs) noted acetaminophen oral tablet 500 mg, two tablets by mouth three times a day for seven days, administered from 12/20/24 through 12/27/24. c. The December MAR noted an additional order for acetaminophen oral tablet 500 mg, two tablets by mouth three times per day for pain/discomfort. It was administered on 12/31/24 at 7:00 p.m. d. Acetaminophen oral tablet 500 mg was discontinued on 1/03/25. e. The January 2025 MARs noted acetaminophen oral tablet 500 mg, two tablets by mouth three times per day for pain/discomfort. Acetaminophen was administered from 1/01/25 to 1/03/25 (two doses). f. Tenant C2's file failed to contain an order for the acetaminophen 500 mg, two tablets, by mouth three times per day from 12/31/24 to 1/03/25. When interviewed on 10/01/25 at 1:37 p.m. the Chief Nursing Officer and Partner with the management company indicated there was no Tylenol order for 12/31/24 found.	A 285		

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A 285	Continued From page 4 2. Record review from 9/29/25 to 10/01/25 of Tenant C2's file revealed a Physician's Order documented an order to admit to hospice (routine level of care) on 1/02/25. Continued record review revealed Progress Notes indicated the following: On 1/03/25 at 4:30 p.m., received orders from Hospice to discontinue all oral medication due to swallowing difficulty. Orders were received to start morphine concentrate solution 20 mg/milliliters (ml), 0.25 ml (5 mg) every four hours scheduled and 0.25 ml every two hours as needed for pain and shortness of breath and Lorazepam Intensol 2 mg/ml, 0.25 ml (0.5 mg) every 4 hours as needed for restlessness or anxiety. The notes indicated the pharmacy received the orders and would send the medications to the Program that night. The orders were put into the electronic record system. On 1/04/25, staff notified the nurse on-call at 5:00 a.m., they went into her apartment to assist with repositioning and she appeared to not be breathing. The nurse on-call notified hospice and the hospice nurse went to the program and confirmed Tenant C2 passed away. Further record review revealed a New Prescription Summary, dated 1/03/25 indicated an order for morphine syringe 5 mg/0.25 ml, take 0.25 ml by mouth every four hours for shortness of breath or pain. The document indicated "[Urgent/Expedited] Terminally Ill Hospice Patient, partial fill allowed." A New Prescription Summary indicated an order for Lorazepam Intensol oral concentrate 2 mg/ml, 0.25 ml (0.5 mg) under the tongue every four hours as needed for anxiety or	A 285		

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A 285	Continued From page 5	A 285		

restlessness or agitation. The date written indicated 1/06/25 (ordered on 1/03/25). The document indicated "[Urgent/Expedited] Terminally Ill Hospice Patient, partial fill allowed."

3. Record review of the January 2025 MARs reflected the discontinuation of oral medications on 1/03/25 as ordered, which included acetaminophen oral tablet 325 mg, give two tablets by mouth, every six hours as needed for pain or fever. It was discontinued on 1/03/25. The MAR reflected no doses had been given as needed for January prior to the discontinuation date. The MAR also reflected the order for morphine sulfate (concentrate) oral solution, 20 mg/ml, give 0.5 ml by mouth every four hours for pain management. There were no reflected doses administered on 1/03/25 or on 1/04/25 before Tenant C2's death. The MAR also reflected the order for morphine sulfate 20 mg/ml, give 0.25 ml by mouth every two hours as needed for pain, difficulty breathing/shortness of breath. There were no as needed doses administered on 1/03/25 or 1/04/25 before Tenant C2's death. The MAR also reflected the order for Lorazepam Intensol oral concentrate 2 mg/ml, give 0.25 ml, by mouth every four hours as needed for restlessness or anxiety. There were no reflected doses administered on 1/03/25 or 1/04/25 before Tenant C2's death.

Continued record review of pharmacy Packing Slip indicated on 1/04/25 (30.00) morphine sulfate solution 100/5 ml were delivered. A pharmacy Packing Slip indicated on 1/06/25 (30.00) lorazepam concentrate 2 mg/ml was delivered.

When interviewed on 10/01/25 at 1:37 p.m. the Chief Nursing Officer and Partner with the management company indicated, she went to see

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A 285	Continued From page 6 Tenant C2 and she could swallow but there were concerns about her swallowing consistently. Staff reported she had a hard time with medications that morning. She assisted with the reposition and she was uncomfortable with the reposition, either painful or agitated. She called hospice and explained it. Hospice was asked if it would be an issue to get the order to the pharmacy and it was indicated it would not be an issue. Pharmacy was called and they had both orders and were told they were needed immediately (morphine the more critical order). Pharmacy indicated it would be on the next run that night. Staff were told to expect it and to call with any concerns with Tenant C2. She did not receive any calls until 5:00 a.m., when staff went to reposition her and they thought she was maybe no longer breathing. Hospice was called to pronounce (related to Tenant C2's death).	A 285		
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.	A 145		

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A 145	Continued From page 7 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 to 1 of 2 discharged tenants reviewed (Tenant C2). Finding follows: Record review from 9/29/25 to 10/1/25 of Tenant C2's file revealed: a. Follow Up Question Report from 12/17/24 to 12/25/24 reflected a one-person physical assist was consistently provided related to the toileting task. The Assisted Living Comprehensive Assessment (90-day review) most recently completed prior to that time was dated 10/16/24. The evaluation reflected Tenant C2 needed assistance with incontinence. The evaluation also reflected staff assisted with toileting every two hours and as needed. The evaluations failed to reflect the assistance as documented by staff for completion of toileting cares with a one-person physical assist. The Program failed to complete evaluations for a change in condition. b. Incident Report Form dated 12/25/24 at 7:45 a.m. revealed Tenant C2 was found sitting in the bathroom doorway asking for help. Staff walked into her apartment with morning medications and observed her sitting on the floor with her pants down to her ankles. She had a "big knot" on her head and her right leg hurt. The incident was reported to the nurse and family. Tenant C2 was taken to the hospital. c. A Tenant Health Review dated 12/25/24, signed on 12/26/24 indicated staff reported Tenant C2 fell. She self-transferred to her bathroom and was found in her doorway with her pants around her	A 145		

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A 145	Continued From page 8	A 145		

ankles. Staff reported she had a "knot" on her head and complained of pain in her legs. Staff was instructed to send her to the emergency department (ED). Tenant C2's family was notified and would meet her in the ED. She returned from the ED splinted because of a closed right wrist fracture and an orthopedic follow up to be determined. Splint checks were put into place and to supervise her while she was splinted. It was noted a significant change assessment would be completed on 12/30/24 "at the next Registered Nurse (RN) opportunity." The review indicated to update the service plan with staff assist with ambulation.

d. Tenant C2's Assisted Living Comprehensive Assessment with an effective date of 12/30/24 was signed on 1/03/25 by the Registered Nurse. The evaluation indicated a significant change. Tenant C2 had difficulty swallowing medications and a poor appetite. She recently lost weight due to decreased intake. Tenant C2 was admitted to hospice. She was oriented to person and unable to make her needs known. There was shallow breathing noted. She had right sided facial bruising and a large hematoma to the right side of her head related to the fall. Tenant C2 had pain, she was unable to describe the location or type of pain and the pain was a seven out of ten on the pain scale. She was not able to take oral hydrocodone/APAP as prescribed by hospice. Morphine would be initiated and lorazepam for terminal restlessness. She was routinely repositioned. She was a maximum assist or non-ambulatory. She required maximum assistance for dressing/undressing, hygiene/grooming, bathing, and continence. It was noted she recently went to the hospital after a fall, had a right wrist fracture (casted) and evaluated for a head injury and facial trauma. She

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A 145	Continued From page 9 required skin checks for the cast and for it to be covered by staff during bathing. She was more somnolent during the assessment, was not able to follow commands and her speech was "incomprehensible." She was visibly uncomfortable with repositioning. She was admitted to hospice on 1/02/25. Routine medications were discontinued and comfort medications were ordered. Staff provided repositioning every two hours and check and change assistance every two hours. She was non-ambulatory and in bed. Further record review revealed the death certificate indicated her cause of death was an ulnar and radius fracture due to fall with underlying causes of cerebral atherosclerosis with vascular dementia and failure to thrive. The manner of death was an accident and the injury was an unwitnessed fall at a memory care program. When interviewed on 10/1/25 at 1:37 p.m. the Chief Nursing Officer and Partner with the management company said one of the nurse consultants (with the management company) was on-call at the time of Tenant C2's fall. She responded with documentation and getting orders and tasks were added. The nurse consultant started the evaluation (12/30/24). She said evaluations could be re-opened later to tell the story or if more occurred. It was charted in the narrative note. She confirmed all evaluations were provided for the tenants reviewed.	A 145		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted	A 350		

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A 350	Continued From page 10 in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed and reflect the service needs of the tenants after a significant change. This pertained to 1 of 3 current tenants reviewed (Tenant #2) and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow: 1. Record review from 9/29/25 and 9/30/25 of Tenant #2's file revealed an Assisted Living (AL) Health and Functional Assessment dated 8/19/25 indicated it was completed for a significant change. The assessment was completed at the hospital with Tenant #2 and his family. Tenant #2 required the assistance of one person with a walker. Tenant #2's family requested for Tenant #2 to start using the walker (versus the cane) and also wanted staff to use a gait belt. Continued record review revealed Tenant #2's service plan signed on 8/20/25 reflected Tenant #2 was independent without a device for transfers and mobility. The service plan signed on 8/20/25 failed be be based on evaluations completed on 8/19/25 and failed to indicate the service needs of Tenant #2.	A 350		

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A 350	Continued From page 11 2. Record review from 9/29/25 to 10/01/25 of Tenant C2's file revealed the following: a. Follow Up Question Report from 12/17/24 to 12/25/24 reflected a one-person physical assist was consistently provided related to the toileting task. b. The most recent Assisted Living Comprehensive Assessment (90-day review), dated 10/16/24, indicated staff assistance with incontinence and toileting every two hours or as needed. The most current evaluations failed to incorporate Tenant C2's one-person physical assist with toileting. c. An Incident Report Form dated 12/25/24,indicated Tenant C2 was found sitting in the bathroom doorway asking for help. Staff walked into her apartment with morning medications and observed her sitting on the floor with her pants down to her ankles. She had a "big knot" on her head and her right leg hurt. Tenant C2 was taken to the hospital. d. A Tenant Health Review dated 12/25/24, signed on 12/26/24 indicated staff reported Tenant C2 had fallen. Staff was instructed to send her to the emergency department (ED). Tenant C2 returned from the ED with a closed right wrist fracture, it was splinted and needed orthopedic follow up. Splint checks were put into place and to supervise her while she was splinted. The review noted a significant change assessment would be completed on 12/30/24 "at next RN (registered nurse) opportunity." The review indicated to update the service plan with staff assist with ambulation.	A 350		

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A 350	Continued From page 12 e. Tenant C2's last service plan was dated 7/18/24. On 12/30/24, the plan reflected a significant change for her right wrist fracture and cast. The plan directed staff to cover her cast with plastic and tape for showers. The staff needed to provide assistance with repositioning, ambulation, and toileting. f. Tenant C2's service plan dated 1/03/25, noted on 1/02/25 she was admitted into hospice. g. The file contained no other service plans to reflect the significant changes with Tenant C2 from 12/17/24 to 12/26/24. When interviewed on 10/01/25 at 1:37 p.m. the Chief Nursing Officer and Partner with the management company said one of the nurse consultants (with the management company) was on-call at the time of Tenant C2's fall. She responded with documentation and getting orders and tasks were added. She confirmed all service plans were provided for the tenants reviewed.	A 350		
A 370	481-69.26(3)a 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. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by:	A 370		

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	S0440	A. BUILDING: _____ B. WING _____	C 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYSON HEIGHTS SENIOR LIVING COMMUNI	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 370	Continued From page 13 Based on interview and record review the Program failed to obtain signed service plans when significant changes occurred. This pertained to 1 of 1 discharged tenants reviewed that had significant changes (Tenant C2). Finding follows: Cross reference: 69.26(1)a for more information related to the significant changes for Tenant C2. Record review from 9/29/25 to 10/01/25 of Tenant C2's file revealed a service plan updated with a change of condition on 12/30/24. The plan was signed by a nurse with the management company. The service plan failed to have a signature by Tenant C2 or Tenant C2's legal representative. Continued record review revealed a service plan updated on 1/03/25 for a change of condition. The service plan failed to have signature by the health or human services professional who updated the service plan and a signature by Tenant C2 or Tenant C2's legal representative. When interviewed on 10/01/25 at 2:20 p.m. the Executive Director confirmed all service plans for the tenants reviewed were provided.	A 370		

Boyson Heights Plan of Correction

Survey Completed 10/1/2025

A150 Program Policies and Procedures

Staff will be re-educated on the Incident, Accident and Medication Error Policy. Education will include needing to complete incident reports timely before the end of the shift for any occurrences as noted in the policy. Education will be completed with all direct care staff by:12/30/2025.

A285 Medications

The program noted that receiving medications timely was an ongoing issue with the primary pharmacy vendor. Effective 11/1/2025 the program is using a new pharmacy vendor partner and has not had concerns with timeliness of medication delivery

All staff re-educated that if a medication is not available, they must notify the on-call nurse. Education completed with all direct care staff by: 12/30/2025.

New DON hired October 2025. Full DON training completed 10/30/2025 that included order and records retention. Program noted deficit in organization and retention of medical records. Part-time medical records staff hired to assist in organization and retention of critical records like orders.

A145 Evaluation of Tenant

New DON hired October 2025. Full DON training completed 10/30/2025 that included timeliness of change of condition assessment expectations of next business day or within 48 hours. DON reviewed Tenant Assessment Policy as part of training. Consultants aware of current expectation and routine chart audits performed at least quarterly to ensure standard being met.

A350 Service Plans: Updates based on tenant needs following a significant change

New DON hired October 2025. Full DON training completed 10/30/2025 that included ensuring tenant assessments match service plan interventions and that tenant needs identified in an evaluation are noted on the assessment. DON reviewed Tenant Assessment and Service Planning Policies as part of training which indicate the standard noted above. Consultants aware of current expectation and routine chart audits performed at least quarterly to ensure standard being met.

A370 Service Plans: Signatures on significant change service plans

New DON hired October 2025. Full DON training completed 10/30/2025 that included specific guidance based on regulation for when service plans need to be signed by tenant or responsible party including change of condition assessments. DON reviewed Service Planning Policy as part of training which indicate the standard noted above. Don and consultants educated on the need to

have significant change assessments signed even in the event of a tenant’s passing. Consultants aware of current expectation and routine chart audits performed at least quarterly to ensure standard being met.