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
	S0479	A. BUILDING: _____ B. WING _____	C 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER POINT HEIGHTS	**800 MUSTANG LANE CENTER POINT, IA 52213**

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A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 28 Number of tenants with cognitive impairment: 6 Total census: 34 There were no regulatory insufficiencies cited related to the investigation Incident #129764-I. The following regulatory insufficiencies were cited related to the investigation of Complaint #127204-C :	A 000		
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 medications at the times indicated on the medication administration records (MARs). This pertained to 8 of 8 tenants	A 285		

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A 285	Continued From page 1 reviewed related to medication administration (Tenants #1, #2, #3, #4, #5, #6, #7 and #8). Findings follow: 1. When interviewed 7/15/25 at 1:24 p.m. Staff C said medications were sometimes late on the weekends due staffing and lack of a structured routine. She said some medications were pushed until after breakfast and sometimes medications were administered at 9:30 a.m. She reported insulin administration was always completed. When interviewed on 7/15/25 at 12:43 p.m. the Executive Director reported there was one time a medication passer was not available to administer medications. It occurred on 3/8/25 from 2:00 p.m. to 6:00 p.m. She said she was new to scheduling and at the time they did not have a contracted staffing agency. She worked with the staff she had at that time. She said she believed all medications were administered; however, some medications might have been late. 2. Record review on 7/15/25 of Tenant #1's file revealed staff administered her medications. Medication Admin Audit Reports for March, June and July 2025 reflected medication variances related to medications not administered at the times indicated on the MAR. The March 2025 report indicated greater than 70 medications not administered within one hour of the time indicated on the MAR. An example included on 3/8/25 Tenant #1 had an order for Novolog, inject 8 units subcutaneously (SQ), scheduled at 4:30 p.m. Staff administered the medication at 7:42 p.m. and documented it as administered at 7:43 p.m. The June and July report (through the	A 285		

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A 285	Continued From page 2 7/15/25 print date) indicated greater than 100 medications not administered within one hour of the time indicated on the MAR. Record review on 7/15/25 of Tenant #2's file revealed staff administered medications. Medication Admin Audit Reports from March, June and July 2025 revealed medications variances related to medications not administered at the times indicated on the MAR. The March 2025 report indicated 10 medications not administered within one hour of the time indicated on the MAR. An example included on 3/27/25 Latanprost Ophthalmic Solution, 0.005% instill 1 drop in both eyes, scheduled at 8:00 p.m. Staff administered the medication at 8:39 p.m. and documented it as administered at 8:40 p.m. The June and July report (through the 7/15/25 print date) indicated 20 medications not administered within one hour of the time indicated on the MAR. Record review on 7/15/25 of Tenant #3's file revealed staff administered medications. Medication Admin Audit Reports from March, June and July 2025 revealed medications variances related to medications not administered at the times indicated on the MAR. The March 2025 report indicated 40 medications not administered within one hour of the time indicated on the MAR. An example included on 3/8/25 insulin lispro injection solution, 31 units SQ in the evening was scheduled at 4:30 p.m. Staff administered the medication at 7:28 p.m. The June and July report (through the 7/15/25 print date) indicated over 70 medications not administered within one hour of the time indicated on the MAR. Another example included on 6/7/25 Tresiba FlexTouch SQ	A 285		

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A 285	Continued From page 3	A 285		

Solution Pen-Injector 200 unit/milliliters (ml), inject 33 units SQ, twice daily was scheduled at 8:00 a.m. Staff administered the medication at 10:03 a.m. and documented the medication at 10:04 a.m.

Record review on 7/15/25 of Tenant #4's file revealed staff administered medications. Medication Admin Audit Reports from March, June and July 2025 revealed medications variances related to medications not administered at the times indicated on the MAR. The March report indicated greater than 15 medications not administered within one hour of the time indicated on the MAR. An example included on 3/8/25 amoxicillin oral tablet 500 milligram (mg), take 1 tablet by mouth three times per day for 5 days was scheduled at 3:00 p.m. Staff administered the medication at 6:07 p.m. and documented the medication administered at 6:08 p.m. The June and July reports (through the 7/15/25 print date) indicated 40 medications not administered within one hour of the time indicated on the MAR.

Record review on 7/16/25 of Tenant #5's file revealed staff administered medications. Medication Admin Audit Reports from March, June and July 2025 revealed medications variances related to medications not administered at the times indicated on the MAR. The March report indicated greater than 30 medications not administered within one hour of the time indicated on the MAR. An example included on 3/17/25 furosemide oral tablet 40 mg, take 1 tablet by mouth twice daily scheduled at 7:00 a.m. Staff administered the medication at 9:17 a.m. The June and July reports (through 7/16/25 print date) indicated greater than 80

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A 285	Continued From page 4	A 285		

medications not administered within one hour of the time indicated on the MAR. Another example included on 6/1/25 furosemide oral tablet 40 mg, take 1 tablet by mouth twice daily scheduled at 7:00 a.m. Staff administered the medication at 10:15 a.m.

Record review on 7/15/25 of Tenant #6's file revealed staff administered medications. Medication Admin Audit Reports from June and July 2025 revealed medications variances related to medications not administered at the times indicated on the MAR. The March report indicated greater than 15 medications not administered within one hour of the time indicated on the MAR. An example included Tears Ophthalmic Solution, instill 1 drop in right eye four times daily was scheduled at 3:00 p.m. Staff administered the medication at 8:36 p.m. and documented the administration of the medication at 8:38 p.m. The June and July reports (through 7/15/25 print date) indicated over 10 medications not administered within one hour of the indicated on the MAR.

Record review on 7/15/25 of Tenant #7's file revealed staff administered medications. Medication Admin Audit Reports from June and July 2025 revealed medications variances related to medications not administered at the times indicated on the MAR. The June and July (through 7/15/25 print date) reflected over 100 medications that were not administered within one hour of the time indicated on the MAR. An example included on 6/20/25 Humalog KwikPen SQ Solution Pen-Injector, inject 16 units SQ once daily scheduled at 11:00 a.m. Staff administered the medication at 1:06 p.m.

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A 285	Continued From page 5 Record review on 7/15/25 of Tenant #8's file revealed staff administered medications. Medication Admin Audit Reports from March, June and July 2025 revealed medications variances related to medications not administered at the times indicated on the MAR. The March report indicated greater than 20 medications not administered within one hour of the time indicated on the MAR. An example included on 3/8/25 Artificial Tears Ophthalmic Solution, instill 1 drop in both eyes four times daily was scheduled at 3:00 p.m. Staff administered the medication at 7:49 p.m. and documented it as administered at 7:55 p.m. The June and July reports (through 7/15/25 print date) indicated over 90 medications not administered within one hour of the time indicated on the MAR. 3. When interviewed on 7/16/25 at 9:39 a.m. the Director of Nursing said there was not a difference in staffing on weekends and weekdays and on weekends sometimes there were two of the three staff that were medication passers. She said medications were routine a.m. or p.m. medications (regarding timeframe) but in the system it was one hour before and one hour after the time. When interviewed on 7/16/25 at 1:35 p.m. the Executive Director reported on the weekends there were three staff and two of the three staff could administer medications; but during the week, all three staff were medication passers (on first shift). She said she heard the expectation was for medications to be administered one hour before and one hour after the time. She confirmed all the medication audit reports had been provided for the tenants reviewed.	A 285		

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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 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 and failed to emsure service plans reflected the service needs of the tenants. This pertained to 2 of 5 tenants reviewed related to level of care (Tenant #4 and Tenant #5). Findings followed: 1. When interviewed on 7/15/25 at 3:03 p.m. Staff A said the assistance of two people was used for Tenant #4 anytime she needed to be moved. She said there was always a second person available that could assist. She said she would not transfer Tenant #5 without (the assistance of two people). She said Tenant #5 could walk a little bit. When interviewed on 7/15/25 at 10:53 a.m. Staff B said Tenant #4 was a hard transfer and sometimes it took two staff to assist her with transfers. She said it was dependent on who was working. She said she could generally get Tenant #4 up with the assistance of one person in the morning but sometimes in the afternoon	A 350		

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A 350	Continued From page 7 she needed the assistance of two people. When interviewed on 7/15/25 at 1:24 p.m. Staff C said Tenant #4 took the assistance of two people for her transfers. Sometimes Tenant #4 was able to bear weight. She said Tenant #5 was also difficult to transfer. She asked for assistance with Tenant #5's transfers. She said Tenant #5 had walked the other day. When interviewed on 7/16/25 at 9:39 a.m. the Director of Nursing said Tenant #4's transfers had been more difficult and her family was looking for a higher level of care. She said Tenant #4 had declined and was not able to walk. Physical therapy said two staff should be used for safety but Tenant #4 was able to be transferred with one person. She said staff changed her in bed on third shift and she did not get up at night. She said Tenant #4 required the assistance of two staff approximatley 25% of the time. She said Tenant #5 required the assistance of one person and at times two people for transfers. She said Tenant #5 mostly required the assistance of one person. She said approximatley 10% of the time Tenant #5 required the assistance of two staff. When interviewed on 7/15/25 at 12:43 p.m. 7/16/25 at 1:35 p.m. the Executive Director said Tenant #4's family was actively seeking a higher level of care. She required the assistance of two people on and off, and it was dependent on who was working. She said maybe 50% of the time Tenant #4 required the assistance of two people. She said on third shift (one staff on duty) staff had been trained on how to change an occupied bed and they were instructed to keep her in bed unless they felt comfortable (to transfer her). She said very rarely did Tenant #5 require the	A 350		

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A 350	Continued From page 8 assistance of two people for transfers. She said recently Tenant #5 had walked to the bathroom. 2. Record review on 7/15/25 of Tenant #4's file revealed the current service plan reflected Tenant #4 had a history of falls, she preferred to use a lift chair in the apartment and she was independent with it. It also indicated she preferred to use a manual wheelchair for mobility and staff assisted with a pivot transfer. The service plan was not updated and did not reflect Tenant #4's needs related to transfers as noted above, including at times the use of two staff. The service plan was also not updated and did not reflect that staff changed her bed on third shift. Record review on 7/16/25 of Tenant #5's file revealed the current service plan to reflected to encourage Tenant #5 to sit as far back in her chair as possible. She preferred to use grab bars and bed rails for bed mobility and transfer assistance. The service plan indicated Tenant #5 required maximum assistance of one person for mobility. Staff assisted her with a gait belt and walker for stand-pivot transfers. Staff also propelled the wheelchair for her. The service plan was not updated and did not reflect Tenant #5's needs related to transfers as noted above, including at times the use to two staff. 3. When interviewed on 7/16/25 at 1:35 p.m. the Executive Director confirmed the current service plans were provided for Tenant #4 and Tenant #5.	A 350		