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
	S0439	A. BUILDING: _____ B. WING _____	C 09/25/2024

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 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: 1 Total census: 29 The following regulatory insufficiencies were cited during the investigation of Incident #121801-I and the recertification visit conducted to determine compliance with certification of an Assisted Living Program.	A 000		
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, staff failed to follow the program's Door Alarm Policy regarding 1 of 1 former tenants reviewed who eloped (Tenant C1). Findings include: 1. Record review on 9/24/24 of an incident investigation dated 6/28/24 revealed Tenant 5 reported to the Business Office Manager that Tenant C1 was outside the night prior on 6/27/24 and had to be let back in the building after Tenant C1 did not know how to get back inside. Tenant C1 had a score of 4 on the Global Deterioration Scale (moderate cognitive decline). A service	A 150	The POC is attached	

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A 150	Continued From page 1	A 150		

plan dated 4/4/24 revealed Tenant C1 had a diagnosis of mixed Alzheimer's and vascular dementia with behavior disturbances. The service plan directed staff to report any changes in mood, behavior, exit-seeking or need or increased services to the nurse. The program's investigation included camera footage showing Tenant C1's exit and subsequent entrance back into the building with the assistance of Tenant 5. There was no evidence on the camera footage of staff members responding to the door by checking the area outside. The incident investigation included a statement from Tenant 5 as well as a statement from Staff A admitting she cleared the door alert without visualizing the door. Staff A subsequently received disciplinary action for not properly responding to the door alarm.

2. During a staff interview with Staff A on 9/25/24 at 10:30 am, Staff A stated she remembered the door alarm alerting on the iPad and remembered clearing the alarm on the iPad without physically going to the door to perform a visual check. She stated it was usually Tenant 5 going out and confirmed she should have gone to the door to see who went outside. Staff A remembered receiving training on door alarm response which was to go outside, look to see if anyone was outside, and walk around the building if needed before going back in. She confirmed these steps would have been the appropriate response when the door alarm alert came to the iPad.

3. On 9/25/24 at 10:45 am, Tenant #5 stated she was outside and recognized Tenant C1 shouldn't be out on the patio. Tenant 5 stated Tenant C1 appeared somewhat agitated, so assisted Tenant C1 back into the building. She then reported what occurred to the Business Office Manager the following morning.

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A 150	Continued From page 2 4. A review on 9/24/24 at 1:03 pm of the program's policy entitled "Door Alarms" instructed staff to follow the following (but not limited to) procedural steps: 1. Staff will immediately respond to all door alarms. 2. The door alarm system will indicate which door has opened. 3. Staff should assume that a tenant caused the alarm to sound and investigate as if a tenant has left the building. Open the door and check if a tenant is in sight. Walk outside and check the grounds and scan the surrounding area. a. Do not assume that is a tenant or visitor is in sight that they caused the alarm, consider that a tenant could have exited the building at the same time as someone else. 4. On 9/25/24 at 12:10 pm, the Nurse Consultant and Executive Director confirmed Staff A did not follow the program's door alarm policy by failing to respond to the door alarm.	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.	A 285		

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A 285	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, program staff failed to properly administer medications as prescribed by the tenant's physician for 1 of 3 tenants reviewed (Tenant 2). Findings include: 1. During observation of a medication administration pass on 9/25/24 at 8:48 am, Staff B administered Tenant 2's AM medications, including 2 capsules of Magnesium Glycinate. The Magnesium Glycinate capsules were administered from a pill bottle indicating each capsule was 200 mg. 2. Record review on 9/25/24 revealed physician orders for Tenant 2 which included Magnesium Glycinate oral capsule 120mg, with instructions to give 2 capsules by mouth one time a day. 3. When questioned on 9/25/24 at 10:27 am, the Executive Director stated the daughter (of Tenant 2) provided the incorrect dosage of Magnesium directly to the resident's apartment without checking it in with the Director of Nursing (DON). The Executive Director further confirmed Tenant 2 had been given the incorrect dosage for two weeks. 4. On 9/25/24 at 12:30 pm, the Executive Director, DON, Nurse Consultant, and Regional Director of Operations confirmed all of the above findings.	A 285		
A 400	481-67.19(3) Record Checks 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a	A 400		

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A 400	Continued From page 4 person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to complete background checks prior to hire for 1 of 7 employees reviewed (Staff B). Findings follow: 1. Record review of the staff list on 9/24/24 revealed Staff B was hired on 11/16/23. The program completed a Single Contact License and Background Check for Staff B on 12/29/23 to determine if Staff B had a criminal history or issues with abuse. There was no history of criminality or abuse, however the background check was not completed for more than one month after her hire date. 2. On 9/24/24 at 1:53 pm, the Executive Director stated the program realized Staff B's background check was missing during an internal self-audit on 12/29/23. 3. On 9/25/24 at 12:30 pm, the Executive Director confirmed the findings.	A 400		

Boyson Heights Senior Living Community ALP Plan of Correction

Re: Findings during Recertification Survey that occurred 9/24/24-9/25/24

1. **A400 Record Checks**
    1. It was determined that the program failed to complete a background check prior to hire.
        a. Pre-employment checklist created for use during hiring process.
        b. Provided re-education to Executive Director and Administrative Assistant regarding the state regulations regarding appropriate background checks and the timeline in which these should be completed.
2. **A285 Medications**
    1. It was determined that a tenant was not receiving the correct dosage of a physician-ordered over the counter medication that was provided by tenant's family member, thus not following physician's orders.
        a. Facility policy adjusted with the following options for medication support to ensure clarity and safety:
            1. Family will set up all medications or all OTC meds in med planner and facility will provide med reminders. Medications will not be administered out of bottles except on a case-by-case basis approved by the RN.
            2. All medications will be set up with the pharmacy for staff administration
        b. Medication aide re-education of 6 rights of medication administration and ensuring tenant is receiving the correct dosage as indicated on the eMAR.
        c. If the nurse needs to receive medications from the family the process was updated to have staff deliver any family-supplied medications directly to the RN or putting them in a designated area in the locked med room if she is not available.
3. **A150 Program Policies and Procedures**
    1. It was determined that staff failed to follow the program's policies and procedures as they relate to the door alarm policy.
        a. Disciplinary action was completed with staff member who failed to follow policy.
        b. All staff education provided on door alarm policy starting on July 1, 2024.
        c. Quarterly elopement drills implemented to ensure ongoing staff awareness and compliance with the policy.
        d. Tenants with appropriate cognitive abilities who regularly go outside provided with key fobs to allow them in and out of the building without activating alarms to reduce alarm fatigue. Staff educated that they must respond no matter what they believe the cause is.