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 12/08/2021

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

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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: 3 TOTAL Census of Assisted Living Program for People with Dementia: 3 An onsite infection control survey was completed and no regulatory insufficiencies were identified. A comment was made to the Program regarding the frequency of tenant vital signs during an outbreak of COVID-19. The investigation of Complaints #99446-C, #10027-C and #100263-C was completed and the following regulatory insufficiencies were identified:	A 000	**See Attached** **POC 2/10/22**	
A 125	481-67.2(1)d Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: d. The incident report shall include statements from individuals, if any, who witnessed the incident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 125		

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

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A 125	Continued From page 1 Program failed to complete witness statements related to an incident. This pertained to 1 of 1 discharged record reviewed (Tenant C1). Findings follow: See 67.3(2) for additional information related to the incident. Record review revealed an incident report signed by Staff B on 10-7-21 documented Staff A found Tenant C1 on his stomach deceased. Staff A came to get Staff B to come back to memory support. Staff B dialed 911 and she handed the phone to Staff A since she could not talk. She called Nurse #1 to get the Executive Director's number and sent a message to the Director of Nursing (DON) to give her a call on her personal cell phone. The date and time of the incident was not documented on the form. The form indicated the instructions to be followed given by the nurse were to call the Executive Director and she called the funeral home. The incident report did not document the time the nurse was notified. The form indicated the Executive Director notified family; however the date and time were not documented. The report indicated the primary care provider (PCP) designee was notified on 10-4-21, but no time was provided. The nurse follow up portion of the incident report, completed 10-1-21 at 8:00 a.m. indicated the Nurse Consultant followed up with the family and there were no questions or concerns at that time. The incident report was reviewed and signed by the DON and Executive Director dated 10-7-21. Continued record review revealed the Program's Accident, Incident and Medication Error Reporting policy and procedure indicated staff would complete an incident report form to document	A 125		

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A 125	Continued From page 2 unusual incidents or accidents, including for tenants. The policy and procedure did not address the completion of witness statements related to incidents. Further record review revealed one incident report was provided for the above noted incident. The report lacked detailed information, including date and time of notifications and the event. The incident report was dated 10-7-21, but the incident occurred 10-1-21. The report included a brief written statement from Staff B; however, none of the other staff involved provided witness statements related to the incident. When interviewed on 12-8-21 at 10:15 a.m. the Executive Director confirmed there were no other incident reports and no witness statements related to the incident with Tenant C1.	A 125		
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 provide adequate and appropriate services, care and treatment. This pertained to 1 of 1 discharged tenant reviewed (Tenant C1). Findings follow: 1. Record review revealed an incident report,	A 160		

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signed by Staff B on 10-7-21, documented Staff A found Tenant C1 on his stomach deceased. The date and time of the incident was not documented on the form. According to the report, Staff A went to get Staff B to come back to memory support. Staff B dialed 911 and handed the phone to Staff A because she could not talk. She called Nurse #1 to get the Executive Director's number and sent a message to the Director of Nursing (DON) to give her a call on her personal cell phone. The nurse directed staff to call the Executive Director and the nurse called the funeral home. The report did not document the time the nurse was notified. The indent report indicated the Executive Director notified family, though no date or time of notification were recorded. The report indicated the primary care provider (PCP) designee was notified on 10-4-21 with no time provided. The nurse follow up portion of the incident report indicated the Nurse Consultant followed up with the family on 10-1-21 at 8:00 a.m. and there were no questions or concerns at that time. The incident report was dated 10-7-21 as reviewed and signed by the DON and Executive Director.

Continued record review revealed a Prehospital Care Report Summary (ambulance report) indicated on 10-1-21 at 6:16 a.m. a call was received and the ambulance dispatched. The document identified Tenant C1 as the patient and indicated the patient was "Dead After Arrival." It was noted Tenant C1 was not breathing and unresponsive. Tenant C1 was documented as cold and skin condition indicated lividity was present. The report indicated they arrived due to a report of a person down. The fire department had been there prior and reported Tenant C1 was deceased and not able to be helped. Tenant C1 was observed face down with his legs down and

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his upper body supported by his walker and bed. Tenant C1 wore "PAJAMA TYPE WEAR AND A THICK FLANNEL SHIRT." Tenant C1 was noted to be "UNRESPONSIVE, APENIC AND PULSELESS... WITH SIGNS PRESENT CONSISTENT WITH OBVIOUS DEATH... SKIN IS COLD TO TOUCH, GROSS LIVIDITY IS PRESENT TO FACE, CHEST AND ANTERIOR ARMS. FULL BODY RIGOR PRESENT." There was an abrasion noted to Tenant C1's left knee. Staff were inconsistent when providing the last time Tenant C1 had been seen. One staff reported 10:00 p.m. the night before and another staff said 4:00 a.m. that morning. The preferred hospital was contacted and a doctor declared the time of death at 6:28 a.m. The medical examiner's office was notified of the unattended death and declined the case. Tenant C1 was picked up from the floor and placed supine in bed, in a restful position and covered with a blanket.

Review of the Certificate of Death documented Tenant C1's date of death 10-1-21 at 6:28 a.m. (found). The place of death was the assisted living program. The cause of death was listed as arteriosclerotic cardiovascular disease.

Continued record review revealed Tenant C1 was admitted to the memory support unit on 8-2-21 and had a diagnosis of Alzheimer's disease. Tenant C1 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. His Health and Functional Assessment dated 9-8-21, indicated Tenant C1 completed most of his activities of daily living (ADLs) with cueing and he did not take any medications. The service plan dated 9-10-21 reflected Tenant C1 was independent with mobility needs and used a walker and had a

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history of falls. Tenant C1 was independent with toileting needs. The service plan did not reflect any scheduled checks for Tenant C1.

Further record review revealed Progress Notes indicated the following:

-On 9-30-21 at 10:00 a.m. the DON noted staff had notified the DON Tenant C1 had a temperature of 101 degrees. Tenant C1 was assessed and reported he did not feel right. It was noted his lung sounds were coarse in the lower lobes and he had a non productive cough. His temperature was rechecked and read 99.8, vitals were as follows: heart rate 98, respirations 18 and oxygen saturation 94%. The PCP and family were notified. Orders were received and fluids were to be encouraged. COVID-19 testing was negative and it was noted "We will continue to monitor resident."

-On 9-30-21 at 1:25 p.m. it was noted Tenant C1 received Tylenol 325 milligram (mg) two tablets, every four hours for an elevated temperature. His temperature was 99.8.

-On 9-30-21 at 5:00 p.m. it was noted Tenant C1 received Tylenol 325 mg two tablets. No temperature was recorded. It indicated the "PRN administration was: Unknown."

-On 10-1-21 at 10:24 a.m. it was noted the Nurse Consultant was informed by the Executive Director Tenant C1 had passed away. The death was pronounced by the fire department at 6:23 a.m. The PCP was notified. Family requested the specific funeral home for assistance and they were notified. The funeral home picked up the tenant at 8:10 a.m. The medical examiner's office called and inquired about previous medical

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history. Family was present in the building and were with Tenant C1's spouse.

Continued record review revealed a verbal order was received dated 9-30-21 for Tylenol 325 mg, take two tablets, by mouth, every four hours, for an elevated temperature.

Further record review revealed the September 2021 medication administration record (MAR) reflected the following:

-An order to screen for fever and respiratory symptoms on day shift (including temperature, pulse, oxygen saturation and respiration rate.

-On 9-25-21 (day shift) Tenant C1's vitals included: temperature of 96.6, pulse 133, respiration rate 17 and oxygen saturation 83 %.

-On 9-30-21 (day shift) Tenant C1's vitals included: temperature of 98.2, pulse 103, respiration rate 16 and oxygen saturation 98.

-An order for Tylenol 325 mg, take two tablets, by mouth, every four hours as needed for elevated temperature with a start date of 9-30-21.

-On 9-30-21 at 1:25 p.m. it was documented Tylenol 325 mg, two tablets were given and was charted as unknown.

The October 2021 MARs did not reflect any documentation of vitals or administration of the as needed Tylenol.

2. When interviewed on 10-13-21 at 9:16 a.m. Staff A reported she worked the first shift on 9-30-21. When she went to get Tenant C1 up that morning he said he did not feel good. She

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requested assistance in the memory unit and the DON came and took him to breakfast. Staff A went to assist another tenant. He was seated for breakfast and did not feel well. Tenant C1 was not himself; he was shaky, confused and his nose was running. She took his temperature and it was well over 100 degrees. She said his temperature was taken eight to ten times. She had been told it was policy that if a tenant had a temperature over 100 degrees they needed to be seen in the emergency room. She reported it to the DON. Staff A left the building at 10:00 a.m. and returned at 10:50 a.m. Staff F filled in while she was gone. The DON said his temperature was 98-99 degrees while she was gone. When Staff A returned to the building she took his temperature again and it was over 100 degrees and very high. At lunch Tenant C1 pushed his food around and was hungry, which was not like him. The DON came to the unit and assessed him, which included giving him Tylenol, checking his heart rate, checking his lungs and asking him questions. She said his lungs sounded "raspy." She told her to take his temperature every one to two hours and to check on him. Tenant C1 could not walk and did not know what was going on. Tenant C1's family members arrived to play a game with Tenant C1's spouse, Tenant #1. Staff A checked on him every hour when he was in his room and took his temperature. It was still over 100 degrees. Before Staff A left, she, another staff, and two family members moved Tenant C1 into Tenant #1's apartment (his spouse), into the rocking chair. Staff A gave report to the oncoming staff, Staff C, who was late and left at 2:20 p.m. She told Staff C to check on Tenant C1 and take his temperature every one to two hours. She told him Tenant C1 was not feeling well, had not eaten much and was not walking well.
The next day Staff A clocked in at 6:02 a.m. and

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walked through the memory care door at 6:04 a.m. Staff D, the overnight staff, was not at the kitchen area where she normally waited Staff A went to the kitchen area and waited for report. Staff D reported how the night was and Staff A asked about Tenant C1. Staff D said she did not go in and check on him because she did not want bother him while he slept, but she did peek her head into the door. Staff D left and Staff A said she felt "weird." She put her bag down and went to Tenant C1's room. She observed there was not a light on, and Tenant C1 never slept without his bathroom light on. When she peeked in the door, she could not see anything except a small part of the bed (not where Tenant C1 would be sleeping). Tenant C1's bed was to the left around the corner, up against the wall. When reported she "smelled death." She walked in and turned on the light and observed Tenant C1 laying face down, his right hand holding the leg of his walker, and his left hand holding his bedspread. His face and chest were not touching the floor and he was touching the ground from the waist down. He had defecated and was cold. She called out for him and he was deceased. It appeared he tried to pull himself up. She said everything was off, Tenant C1's bed was still made and he was in the same clothes when she left the day prior. Tenant C1 was not in pajamas, which he always wore. Staff A said she was in complete shock, attempted to call staff on the walkie talkie (which did not work). She went to the door of the memory unit and called for the other staff on the assisted living side without success. She then ran to the entrance where the nursing desk was located and found Staff B. They ran to the memory care unit and she went in to verify everything that happened. Staff did not have the Executive Director's number or the DON's number to call. On a building group chat she said

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Tenant C1 was found face down and 911 was called. The Executive Director said she should not have called 911 and should have contacted the DON so she could complete an assessment. Staff A told her Tenant C1 was deceased. The Executive Director said she was not coming in until her scheduled time. The Executive Director said staff was responsible to notify Tenant C1's family. The Executive Director called Staff B and gave her the DON's number. Staff B called the DON and was told she was not coming in as it was her day off. Two overnight shift staff came back to the building, Staff D and Staff E. The fire department and emergency medical technicians (EMTs) arrived. They asked why there was not proper reporting and when Tenant C1 was last checked. They said he had been gone for hours and could have deceased the day prior. The funeral home came in and took Tenant C1.
Staff A notified Tenant C1's family before 7:00 a.m. Family asked if Tenant #1, Tenant C1's spouse, knew and asked to be called when Tenant #1 woke up. Tenant C1's family was notified and came into the building after 9:00 a.m. and asked what happened. Staff A informed her of what happened and she found him. She said the family was very upset.
Staff A reported there was a meeting with a Nurse Consultant, Staff A, Staff B and another administrative staff. In the meeting it was discussed to tell the family Tenant C1 died peacefully. Due to distress, staff was told they could say (to other tenants) that Tenant C1 had passed. Staff A said the next day she was not able to get into the group system used. There was a meeting planned on the following Monday and Staff A said she resigned. She did not receive training on post mortem care, she had not received training on an unobserved death and did not have training on when to call the nurse.

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There were no numbers available to contact the Executive Director or DON, the contact was made through a group chat system. She said the police and medical examiner were not contacted by the Program. She did not complete an incident report or witness statement.
When Staff A reported Tenant C1 did not have scheduled checks but staff had to ensure they had eyes on them and made sure they were out to meals, saw them at snacks, and medication times.

When interviewed on 10-25-21 at 2:15 p.m. Staff B reported on 10/1/21 Staff A came out of the memory care unit and could not get her words out and told her Tenant C1 was deceased. Staff B went to the memory care unit with Staff A and went to Tenant C1's apartment. She observed the tenant right next to his bed with his left hand grasping his comforter and the right hand grasping the walker. Tenant C1's chest was off the ground and his legs were on the ground. He wore blue jeans, slippers, a red plaid coat and did not wear night clothes. Staff A told her Tenant C1 wore the same clothes as the day prior. Tenant C1 normally wore a white t-shirt and underwear or pajama pants to bed. Tenant C1 was not in those clothes and his bed was made. There was blood on the ground next to his left knee. Staff called 911. Nurse #1 (with corporate) was called as staff did not have the Executive Director's phone number. Nurse #1 gave staff the Executive Director's number. The Executive Director called and told staff to call the DON. The DON was contacted and the DON said she had taken the day off and was not coming in. Staff A had put into the group chat that 911 was called. Staff D and Staff E came back. Staff D was on the phone with the Executive Director and said to call the family and funeral home. Staff A had already

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contacted one of Tenant C1's family members. The Executive Director contacted the funeral home. EMTs and the fire department responded and the EMTs said it appeared the tenant had been there for hours. The EMTs asked when he was last checked and Staff D said 2:00 to 3:00 a.m. Staff D had told Staff A she had not checked on him. Staff A, Staff B, the Nurse Consultant and the Executive Director had a meeting after. Staff A and Staff B were deleted out of the group messaging system. Staff B did not have training on unobserved death or post mortem care and no training on the incident with Tenant C1. Tenant C1 had no scheduled checks; however, his spouse had two hour checks. The checks were not documented.

When interviewed on 10-13-21 at 2:13 p.m. Staff C reported he worked second shift on 9-30-21 in the memory care unit. Offgoing first shift staff told him Tenant C1 was not feeling well and that he did not eat. Staff C first saw Tenant C1 in his spouse's room when staff went room to room at shift change. Between 2:00 p.m. - 3:00 or 3:30 p.m. Staff C helped him to the restroom and said he took everyone to the restroom every two hours unless they refused. Tenant C1 was not feeling well. Tenant C1 ate most of his meal and then wanted to go to bed at approximately 6:20 p.m. He helped him back to the room, assisted Tenant C1 to put on his pajamas, took him to the bathroom and took his temperature, which was 101.8. Staff C said he sent a text message (group chat) at 6:39 p.m. that Tenant C1 was weak. Staff C checked on him at 7:30 p.m. and he was awake and in bed. At 8:30 p.m. he checked on him and Tenant C1 wanted to use the restroom so he helped him. At about 9:00 p.m. - 9:20 p.m. he checked on Tenant C1 and he was half asleep in bed. At about 9:40 p.m. - 9:45 p.m.

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Tenant C1 was sleeping and was in bed. Staff C could not see his clothing as he was covered up. That was the last check of Tenant C1 on his shift. At 10:00 p.m. he gave report to the third shift staff. He told the staff Tenant C1 was weak and he had walked him to his room after supper. He also reported he had a temperature of 101.8 and to keep an eye on him. He said he sent a message in an application (that was no longer working) at 6:39 p.m. on 9-30-21 about walking him back after supper, he ate almost all of his dinner and was weak. Staff C reported he checked on all tenants every two hours with toileting assistance. Tenant C1's temperature was taken one time on the second shift and it was 101.8. It was not recorded but was still in his phone (message in the application) at 6:39 p.m. Staff C had not received training regarding when to call the nurse, post mortem care or training on an unobserved death.

When interviewed on 10-18-21 at 9:37 a.m. Staff D reported she worked third shift and came into work at 9:50 p.m. Staff C was the offgoing second shift staff and reported Tenant C1 had a slight fever and was not acting like himself. She started cleaning and checked on the tenants at 10:00 p.m. It was communicated to her by the previous DON that Tenant C1 and one other tenant in the memory care unit did not require checks every two hours. She had been directed to check on them at least once or twice per night and not every two hours, as they did not like to be disturbed or woke up. At 10:00 p.m. she checked all of the tenants, including Tenant C1. He was asleep, in bed, laying on his back. She went into his room and checked that he was okay and breathing. His chest was going up and down. He was covered up with two blankets. At 12:00 a.m. she checked on Tenant C1 and he laid on his

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side, facing the wall and he was asleep. The bathroom light was on and the door was open. She checked the toilet and there was nothing in it. She observed his chest go up and down. At 2:00 a.m. she checked on him for the last time. He was laying on his back in bed and was asleep. The bathroom door was half way open and the bathroom light was on. At the other checks the bathroom door was fully open. She thought it looked like Tenant C1 went to use the bathroom. Tenant C1's walker was close to the heater/air conditioner unit. At the other checks his walker was right next to his bed, in the middle of the length of his bed. Staff D said about 2:00 a.m. was the last time he was checked because Tenant #2 tried to get into other tenant apartments and banged on the doors. Tenant #2 was loud and cursed and had woken up Tenant #1. She locked everyone's doors. Tenant #2's behaviors ended at about 4:30 a.m. to 4:40 a.m. When he calmed down she finished cleaning. She had no other interaction with Tenant C1. She said typically he was checked at 10:00 p.m., 12:00 a.m. and 4:00 a.m. She could not check on him at 4:00 a.m. because of Tenant #2. She did not want Tenant #2 to wake everyone up. Staff D said Staff A came in about 6:00 a.m. and said she had told the DON about Tenant C1 having a temperature. Staff D told Staff A that Tenant #2 had behaviors and she did not check on Tenant C1 at 4:00 a.m. and the last check was 2:00 a.m. She finished report and left. About 10 minutes later Staff E called her and told her something was wrong with Tenant C1. She returned to the building. She went into memory support and Staff A, Staff B, Staff E were present. The EMTs asked for the DON. Staff B called the DON and was told she could not do anything because she was not the nurse yet. They tried to figure out what to do and she said normally the

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DON would tell them what to do and they did not have a nurse. They did not know what to do. Staff A was told to call the power of attorney (POA) and Staff A called a family member, not the POA. Staff D thought staff could not call families. EMTs told staff Tenant C1 had been deceased for four hours and asked when the last check was completed. Staff D did not go into Tenant C1's apartment when she returned to the building and she said the last time she saw him was at 2:00 a.m. Staff D contacted the Executive Director and told her about the situation. The Executive Director said it was the EMTs job to notify the funeral home. The EMTs said it was not their job and the Program needed to notify the funeral home. Staff E told Staff D the EMTs put Tenant C1 in bed. Staff E told her Tenant C1 was in a white shirt and blue pants. When she checked on him at the checks he was wearing a white shirt.

Staff D said she had not received training on post mortem care, unobserved death or when to notify the nurse. The nurse was now working on it. She said there was no phone inside the building except at the front desk. In memory support there was a white phone and she did not know how to use it. Staff had been given permission to use their personal cellular phones. The numbers for the Executive Director and DON were posted in the application. To reach the assisted living side she would text, there were radios (walkie talkies) however, they did not work.

Staff D reported she typically checked Tenant C1 at 10:00 p.m., 2:00 a.m. and 4:00 a.m. She said he never called for help and did not have a pendant. Tenant C1 was typically asleep when she arrived and asleep when she left her shift. Staff D did not check his temperature on her shift and he did not have any medications at all. She knew he was sick as he did not awaken when she

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A 160	Continued From page 15 was in his room. When interviewed on 10-18-21 at 11:26 a.m. Staff E said he worked third shift and had left the building. He was up the street when there was a message in the group chat that Tenant C1 was face down (message deleted). He went to the memory support unit and went to Tenant C1's apartment. Tenant C1 was face down but not completely face down, his hands were holding his walker. He was wearing a white shirt and blue pajama pants. The bed was unmade. He called his name three times and there was no answer. He was slightly cold to the touch, had discoloration in his fingers, and was pale. Tenant C1 had also defecated. Staff called 911. Staff did not have the documentation to give them with Tenant C1's date of birth or age. EMTs asked questions and pronounced the death. The fire department and EMTs picked him up and put him into bed. It could not be figured out why he was the way he was, if he got up and fell. Staff B called the DON and was told she was not coming in. Staff A called the Executive Director or DON and were told to handle it by themselves. Staff A called Tenant C1's family member. Prior to his death, Staff A noticed Tenant C1 had a fever and texted the DON. Staff A left the building and returned and his fever went to 99 something. Messages were sent to the DON asking how did she get his fever to go down. Staff C had also sent a message in the group chat regarding Tenant C1 being weak and there was no response. Staff E said he had not been trained on when to notify the nurse, post mortem care or unobserved death. Staff E did not complete a staff or witness statement. When interviewed on 10-19-21 at 12:30 p.m. the Activities Director said received a message	A 160		

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before she came to work that Tenant C1 was on the floor. She received a telephone call from the Executive Director and was made aware that Tenant C1 was deceased and asked her to keep an eye on the assisted living side of the building. At approximately 8:00 to 8:15 a.m. the Executive Director called and asked her to shut the blinds in the dining room and to let her know the funeral home staff was coming and to let them into the building and into memory support. The Activities Director let them into the building and the funeral home staff went to his apartment. The Activities Director talked to Staff A and Staff B and said they were shaken up about what had happened.

When interviewed on 10-20-21 at 1:01 p.m. the Nurse Consultant said she worked the day before Tenant C1's death when staff reported Tenant C1 was not feeling well. The DON completed an assessment, obtained an order for Tylenol, contacted his family and provider. She received a telephone call from the Executive Director at 7:25 a.m. the following morning and she said Tenant C1 had died and asked for assistance. The Executive Director did not have remote access to their electronic medical records system and needed his date of birth and PCP. She called the funeral home and told them the death was pronounced by the fire department and EMTs. A telephone call was out to the PCP to release the body to the funeral home. The PCP was out of the office and another provider gave the order to release the body to the funeral home. The funeral home called back with time of their arrival. She arrived at the Program that morning and went to the memory support unit to visit with the staff that were upset. One staff had never taken care of a deceased tenant and one staff had but in a different healthcare setting. Tenant C1's family was there with Tenant C1's spouse.

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She spoke with Staff A and Staff B on the patio outside and at some point in the meeting the Executive Director joined. It was a debriefing of what occurred and they discussed the employee assistance program. Staff expressed they could not continue on their shifts and were visibly upset. She found out staff observed Tenant C1 on the floor and paramedics transferred him to bed. Staff had questions regarding the last time Tenant C1 was checked and about him being on the floor. She received a telephone call from a person in the medical examiner's office to verify medical history, PCP, next of kin and another call was received later from the medical examiner to seek clarification of the PCP. She said regarding the date of the incident report (10-7-21) that Staff A was supposed to complete it and did not complete it before she resigned. She said the DON was not on call at the time of incident and Nurse #1 was on-call.

When interviewed on 10-28-21 at 10:02 a.m. Nurse A said she would take nurse on-call between changes with the DON of position. She would split on-call with the consultant nurse. She said early on the morning of 10-1-21, at shift change, Staff B called and said they found the tenant (Tenant C1) deceased. Nurse A told her to call 911 and they had already done that. She told her to call the Executive Director and the coverage nurse. Staff B asked for the Executive Director's number and she gave her the number. The day prior on 9-30-21 she did not recall being contacted by staff.

When interviewed on 10-19-21 at 10:00 a.m. the DON said on the morning of 9-30-21 staff needed assistance in the memory support unit and she went to help. It was the first time she met Tenant C1. She assisted him and took him

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out to the table to sit with his spouse. Staff A said Tenant C1 had an elevated temperature and it was a low grade temperature when the DON checked. She completed an assessment of him and he was COVID-19 negative via rapid test. Tylenol as needed was ordered, the family was contacted and the PCP was notified. Fluids were to be encouraged and staff were to notify her of any changes. The DON did not work the following day. The next day Staff B spoke with the DON and told her Tenant C1 had passed away. She was not alarmed and was not on-call. The DON redirected Staff B to call the Executive Director. She told her the Executive Director would walk her through the process. No other staff contacted her that morning. In the group chat system Staff A sent a message she was going to leave the building and she found that alarming. The message was erased. There were no messages the day prior in the group chat system regarding Tenant C1. She said the Executive Director notified the family (not witnessed). Regarding the policy regarding a death, she was unsure of the policy and the Executive Director and the consultant were going over it. Staff was directed to notify the DON in the event of death. She said regarding rounds or checks, that two hour rounds were standard in memory care. She did not know if Tenant C1's checks were documented.

When interviewed on 10-19-21 at 11:33 a.m. the Executive Director reported the Program did not have a policy regarding unobserved death or post mortem care and it was case by case. They followed the CPR policy and resuscitation documentation and would call 911. She said the safety checks in memory care were every two hours and that had been in place when the building opened. She said the DON had created

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a document for the checks, but was not sure about documentation of checks prior to the development of the form. The Executive Director reported the Program started using a new group chat system on 9-28-21 and all messages from 9-30-21 and 10-1-21 were in the new group chat system. She said the writer of the message could delete the message.
She said she received a telephone call at 6:29 a.m. from Staff A screaming on the phone Tenant C1 had died. She had already called 911 and the fire department and EMTs were at the building and had already pronounced Tenant C1's death. The Executive Director reached out to Nurse #1 and the PCP provider's office was contacted to release the body. The funeral home was also contacted. The Executive Director contacted the family. Staff A had already contacted a family member, though she had not received direction to do so. The Activities Director and other staff managed the assisted living side. Staff A and Staff B were upset regarding the situation. There was a debriefing and staff were able to express their concerns and what they felt. They listened, understood and the staff was able to speak freely. The Executive Director left the meeting for a discussion with family. Staff were replaced for the remainder of their shifts per their request.
The Executive Director did not observe Tenant C1 as the funeral home was gone before she arrived. She said staff should have called the Executive Director first and then called 911. She would have reached out to Nurse #1. She said the DON was not on-call at that time. She interviewed Staff D and determined she checked on him according to his service plan. The Executive Director confirmed Tenant C1 did not have a pendant when he was in memory support.

When interviewed on 10-25-21 at 4:24 p.m.

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Tenant C1's legal representative said he visited his parents on 9-29-21 and Tenant C1 seemed fine. The next day he did not get there to visit. Staff called, he thought it was the DON, and said he was running a low grade temperature and asked if he could get Tylenol. He said to go ahead. There was nothing else communicated except the low grade temperature or he would have made a visit. The next day a family member called and said Tenant C1 had passed away. He was not notified by staff of Tenant C1's passing; however, was notified by his family member. The legal representative said he was not told a COVID-19 test was completed and he did not believe it was offered to take Tenant C1 to the hospital or doctor's office. He said he seemed fine on Wednesday and was gone on Friday. They had just been talking about him hitting 100 years old and all of the sudden he was gone. He said one person called on Thursday regarding the low grade temperature and he later heard it was a temperature of 103. The medical examiner said they did not test for COVID-19 as the Program said the test was negative. A visitation for Tenant C1 was supposed to be on 10-4-21; however, Tenant C1's spouse (Tenant #1) and a family member tested positive for COVID-19. Tenant C1 spent a lot of time at his spouse's apartment.

When interviewed on 10-26-21 at 4:04 p.m. Tenant C1's family member said she tried to visit everyday to see him. The day before he passed, staff said he was not feeling well and had a low grade fever. When she left, Tenant C1 and Tenant #1 were both in Tenant #1's apartment. On 10-1-21 at 6:30 a.m. she received a telephone call from Staff A, who said Tenant C1 had passed away. She said he was holding on to his walker and there was blood on the floor. Staff A said his temperature was 103 and he was shaky and cold.

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She was not told that until after his death. Tenant C1's legal representative was told his temperature was a low grade temperature. Tenant C1's legal representative was not asked if he wanted to send him to the hospital. The medical examiner said Tenant C1 was not tested for COVID-19 because he was negative. Tenant C1's viewing was canceled due to COVID-19, as Tenant #1 tested positive.

3. Record review of the group chat messages to the "Entire Team" for 9-30-21 provided by the Program included the following:

-On 9-30-21 at 8:44 a.m. Staff A requested assistance in memory support due to assisting Tenant #2 with a shower.
-On 9-30-21 at 8:45 a.m. the DON responded that she was on her way.
-On 9-30-21 at 10:20 a.m. there is a message sent regarding non tenant laundry items.
-On 9-30-21 at 2:19 p.m. the Activities Director sent a message regarding crepes in the Hospitality Hub left over from an activity.

There were no other messages in the group chat for the "Entire Team" after 8:44 a.m. on 9-30-21 provided by the Program (there were other messages provided prior to 8:44 a.m.).

The next message in the group chat for the "Entire Team" for 10-1-21 provided by the Program indicated the following:

-On 10-1-21 at 5:41 a.m. a message by Staff E was deleted. The note indicated Staff E deleted the message.
-On 10-1-21 at 6:16 a.m. a message by Staff A was deleted. The note indicated Staff A deleted

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the message.
-On 10-1-21 at 6:17 a.m. a message by Staff A was deleted. The note indicated Staff A deleted the message.
-On 10-1-21 at 7:19 a.m. Staff A sent a message that asked if any staff could fill in for memory support and assisted living.

Record review of screen shots of the messages between Staff A and the DON in the Program's group message system, provided by staff indicated the following:

-On 9-30-21 at 9:42 a.m. Staff A sent a message to the DON and said Tenant C1 had a fever and she had taken it three times and he was acting "weird."
-On 9-30-21 at 12:07 p.m. Staff A sent a message to the DON and said she was aware the DON had taken his temperature but Staff A was worried about him, he did not eat breakfast like normal and the staff that assisted could not get him to walk to lunch. The message showed a picture of a thermometer with a reading that appeared to indicate 101.6 and an elderly man in the background of the picture.
-On 9-30-21 at 12:07 p.m. Staff A said she had taken his temperature and said no matter how many times it was taken it was always a temperature. She asked how the DON got his temperature under 100 and said Tenant C1 was warm and shaky.
-On 9-30-21 at 12:12 p.m. Staff A sent a message to the DON she was going to put him to bed after lunch and he wanted to sleep.
-On 9-30-21 at 12:12 p.m. the DON responded that she was coming back to do his assessment.
-Date unknown at 6:56 a.m. a message sent from Staff A to the DON to call agency.
-Date unknown at 6:57 a.m. the DON sent a

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message to Staff A to call the Executive Director as the DON was not in the office that day.

Record review of screen shots of the messages in the Program's group message system for the "Entire Team" provided by staff indicated the following:

-On 9-30-21 at 2:19 p.m. the Activities Director sent a message regarding crepes in the Hospitality Hub left over from an activity. (this was the same message, date and time as provided by the Program).
-On 10-1-21 at 5:41 a.m. a message sent from Staff E that was deleted (this was the same message, date and time as provided by the Program).
-On 10-1-21 at 6:16 a.m. Staff A sent a message that indicated 911 was called. (this was the same date and time of a message deleted as provided by the Program).
-On 10-1-21 at 6:17 a.m. Staff A sent a message that indicated Tenant C1 was on the floor face down (this was the same date and time of a message deleted as provided by the Program).

Record review of screen shots of the messages in the Program's group message system between Staff and A and Staff D, provided by staff indicated the following:

-On 10-1-21 at 6:27 a.m. Staff A sent a message and asked when Staff D last checked on Tenant C1.
-On 10-1-21 at 7:25 a.m. Staff D sent a message to Staff A and said 2:30-3:30.

There were no messages provided by Program related to messages sent by Staff A to the DON regarding Tenant C1's temperature or condition

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	S0440	A. BUILDING: _____ B. WING _____	C 12/08/2021

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 160	Continued From page 24	A 160		

change on 9-30-21 or Staff C's message related to Tenant C1's temperature and weakness on 9-30-21. There were also no messages provided by the Program regarding Staff A and Staff D's messages of when Tenant C1 was last checked.

4. Continued record review revealed the Program's Staffing policy and procedure indicated the Program would have one or more staff who monitored the tenants as indicated in their service plans. Staff would check on tenants as indicated in their service plans.

In summary, Tenant C1, who had moderately severe cognitive decline, had elevated temperatures when taken on 9-30-21, was not acting like himself, was weak, required assistance walking and did not eat as he normally did. Staff A reported she took his temperature 8 to 10 times on the first shift and Staff C reported he took his temperature once on second shift. Staff D did not take Tenant C1's temperature on the third shift. Staff A communicated the elevated temperatures to the DON. There was one recorded temperature on the MAR, which did not reflect an elevated temperature. A temperature of 99.8 was recorded when Tylenol was given at 99.8 at 1:25 p.m. There were no other documented temperature readings on 9-30-21 or 10-1-21 provided in Tenant C1's file. Tylenol as needed was ordered to be given every four hours and Tenant C1 did not previously take any medications. There was one documented dose of Tylenol as needed administered at 1:25 p.m. the effectiveness of the medication was charted as unknown. There was entry in Progress Notes regarding an administration note for Tylenol as needed; however, no other doses were signed on the MAR. As Tenant C1's condition changed

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A 160	Continued From page 25 there was no documented instruction for staff related to change in condition and directives related to his declining condition. Tenant C1's service plan did not reflect scheduled checks as required by the Program's policy and by administrative rule. Staff D reported in an interview she last checked on Tenant C1 at 2:00 a.m. Staff A reported Staff D told her at shift change that she did not check on him as she did not want to wake him but peeked her head in. The length of time Tenant C1 went without being checked could not be determined; however, EMTs told staff Tenant C1 had been deceased for at least four hours. The ambulance report indicated the following regarding Tenant C1: "PT IS COLD TO TOUCH, GROSS LIVIDITY IS PRESENT TO FACE, CHEST AND ANTERIOR ARMS. FULL BODY RIGOR PRESENT." There were no documented safety checks provided related to Tenant C1. After Tenant C1 was found deceased staff reported difficulty contacting leadership staff, including a nurse on-call. They also reported not receiving training regarding protocols and lack of direction provided related to the incident. Tenant C1 did not receive services, care and treatment that was adequate and appropriate related to his illness and condition change on 9-30-21, related to lack of documented checks and specification of those checks in his service plan, related to the lack notification of Tenant C1's family/legal representatives regarding details of the change of condition and post mortem cares and services.	A 160		
A 360	481-69.26(3) 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	A 360		

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A 360	Continued From page 26 and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans within 30 days of taking occupancy. This pertained to 2 of 2 tenants admitted from 8-1-21 to current (Tenant #2 and Tenant C1). Findings follow: 1. Record review of Tenant #2's file revealed an admission date of 8-25-21. Continued record review revealed Tenant #2's service plan, dated 9-30-21. The service plan was not developed within 30 days of taking occupancy. 2. Record review of Tenant C1's file revealed an admission date of 8-2-21. Continued record review revealed his service plan, dated 9-10-21. The service plan was not developed within 30 days of taking occupancy. 3. When interviewed on 12-8-21 at 10:15 a.m. the Executive Director confirmed those were the most current service plans for tenants listed above. She had a completed date of 9-8-21 for Tenant C1's service plan.	A 360		
A 530	481-69.29(4) Staffing 481-69.29(231C) 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	A 530		

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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 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 ensure service plans reflected the frequency of checks for tenants residing in dementia-specific programs. This pertained to 1 of 2 current tenants reviewed (Tenant #2) and 1 of 1 discharged tenants reviewed (Tenant C1).

1. Record review revealed Tenant #2 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. The service plan dated 9-30-21 reflected Tenant #2 was to receive "routine safety checks." The service plan failed to indicate the frequency of the checks to be provided.

2. Record review revealed Tenant C1 was staged at a five on the GDS, which indicated moderately severe cognitive decline. The service plan dated 9-10-21 failed to reflect safety checks for Tenant C1.

Continued record review of an incident report signed by Staff B on 10-7-21 indicated Staff A found Tenant C1 on his stomach deceased. Staff

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A came to get Staff B to come back to memory support. Staff B dialed 911 and she handed the phone to Staff A since she could not talk. She called Nurse #1 to get the Executive Director's number and sent a message to the Director of Nursing (DON) to give her a call on her personal cell phone. The date and time of the incident of the was not documented on the form. The form indicated the instructions to be followed given by the nurse indicated to call the Executive Director and she called the funeral home. The time of the nurse notification was not completed. The form indicated the Executive Director notified family and there was no date and time of the notification recorded. The report indicated the primary care provider (PCP) designee was notified on 10-4-21 with no time provided. The nurse follow up portion of the incident report indicated the Nurse Consultant followed up with the family and there were no questions or concerns at that time. The death certificate would be signed by the PCP. The nurse follow up was documented at 10-1-21 at 8:00 a.m. The incident report was reviewed and signed by the DON and Executive Director dated 10-7-21.

A Prehospital Care Report Summary (ambulance report) indicated on 10-1-21 at 6:16 a.m. a call was received and the ambulance was dispatched. The document identified Tenant C1 as the patient and indicated the patient was "Dead After Arrival." It was indicated Tenant C1 was not breathing and "Obvious Death." The skin temperature was documented as cold and skin condition indicated lividity was present. They arrived for a report a person down and the fire department was there prior and reported Tenant C1 was deceased and not able to be helped. Tenant C1 was observed face down with his legs down and his upper body supported by his walker and bed. Tenant C1 was

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wearing "PAJAMA TYPE WEAR AND A THICK FLANNEL SHIRT." Tenant C1 was noted to be "UNRESPONSIVE, APENIC AND PULSELESS, PT WITH SIGNS PRESENT CONSISTENT WITH OBVIOUS DEATH. PT SKIN IS COLD TO TOUCH, GROSS LIVIDITY IS PRESENT TO FACE, CHEST AND ANTERIOR ARMS. FULL BODY RIGOR PRESENT." There was an abrasion noted to the left knee. Staff was inconsistent related to the last time Tenant C1 was seen. One staff said 10:00 p.m. last night and another staff said 4:00 a.m. that morning. The preferred hospital was contacted and a doctor declared time of death at 6:28 a.m. The medical examiner's office was notified of the unattended death and declined the case. Tenant C1 was picked up from the floor and placed supine in bed, in a restful position and covered with blanket.

See 67.3(2) for additional information related to the incident.

When interviewed on 10-18-21 at 9:37 a.m. Staff D reported she worked third shift and came into work at 9:50 p.m. Staff C was the off-going second shift staff and he reported that Tenant C1 had a slight fever and was not acting like himself. She started cleaning and checked on the tenants at 10:00 p.m. It was communicated to her by the Previous DON that Tenant C1 and one other tenant in the memory care unit did not require checks every two hours and to check on them at least once to twice per night and not every two hours, as they did not like to be disturbed or woke up. At 10:00 p.m. she checked all of the tenants, including Tenant C1. He was asleep, in bed, laying on his back. She went into his room and checked that he was okay and breathing. His chest was going up and down. The bathroom

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door was open and the bathroom light was on. He was covered up with two blankets on. At 12:00 a.m. she checked on Tenant C1 and he was laying on his side, facing the wall and was asleep. The bathroom light was on and the door was open. She checked the toilet and there was nothing in it. She observed his chest went up and down. At 2:00 a.m. she checked on him for the last time. He was laying on his back in bed and was asleep. The bathroom door was half way open and the bathroom light was on. At the other checks the bathroom door was fully open. She thought it looked like Tenant C1 went to use the bathroom. Tenant C1's walker was close to the heater/air conditioner unit. At the other checks his walker was right next to his bed, in middle of the length of his bed.
She said about 2:00 a.m. was the last time he was checked because Tenant #2 tried to get into other tenant apartments and banged on the doors. Tenant #2 was loud and cursed and had woken up Tenant #1. She locked everyone's doors. Tenant #2's behaviors ended at about 4:30 a.m. to 4:40 a.m. When he calmed down she finished cleaning. She had no other interaction with Tenant C1. She said typically he was checked at 10:00 p.m., 12:00 a.m. and 4:00 a.m. She could not check on him at 4:00 a.m. because of Tenant #2. She did not want Tenant #2 to wake everyone up.
Staff D said she typically checked Tenant C1 at 10:00 p.m., 2:00 a.m. and 4:00 a.m. She said he never called for help and did not have a pendant. She knew he was sick as he did not awaken when she was in his room. She said it policy to tell staff what to do would have been helpful.

3. Record review revealed there were no documented checks for Tenant #2 or Tenant C1's

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A 530	Continued From page 31 prior to 10-1-21, including on 9-30-21 and 10-1-21. When interviewed on 10-19-21 at 11:33 a.m. the Executive Director reported safety checks in memory care were completed every two hours and that had been in place when the building opened. She said the DON had a created a document for documentation of the checks since Tenant C1's death, but she was not sure about documentation prior to that. In summary, the tenants in memory support, including Tenant #2 and Tenant C1 did not have pendants. Tenant #2 and Tenant C1 did not have specific safety checks reflected on their service plans. On 10-1-21 Tenant C1 was found deceased by first shift staff and EMTs indicated Tenant C1 had been deceased a length of time, staff interviews varied on the time provided by EMTs. Staff A said Staff D first reported at shift change she did not check on Tenant C1 as she did not want to bother him, but peeked her head into his apartment. Staff D reported in interview she checked on him last at 2:00 a.m. The checks that were completed for Tenant C1 were not documented. The service plan for Tenant #2 lack frequency of the safety checks and the service plan for Tenant C1 lacked any mention of safety checks or frequency of checks.	A 530		

ok

On behalf of Boyson Heights Senior Living Memory Support, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Monitoring Report dated 12/08/2021. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of state law.

Program Policies and Procedures

1. Elements detailing how the Program will correct each regulatory insufficiency
    - Program's Accident, Incident and Medication Error Reporting policy has been updated to include the completion of witness statements by individuals witnessing an incident.
2. Measures taken to ensure the problem does not recur
    - Witness statements will be completed by all individuals witnessing an incident.
3. How the Program plans to monitor performance to ensure compliance
    - RN and program director will review all incident reports for completion, including completion witness statements.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected by February 10th, 2022.

Tenant Rights

1. Elements detailing how the Program will correct each regulatory insufficiency
    - On call nurse schedule and contact information is posted for staff.
    - Program has adopted a policy for Death of a Tenant.
    - Upon a noted change in condition, RN will assess tenant and update service plan to include services, care, and treatment that is adequate and appropriate related to illness and condition change.
    - Tenants requiring routine safety checks will have the frequency of checks addressed on the service plan.
2. Measures taken to ensure the problem does not recur
    - All staff have been educated on the location of RN on call information.
    - Nursing staff have been educated on the policy for Death of a Tenant. Nursing staff have been delegated on postmortem care.
    - RN has been educated on change in condition assessment requirements and requirements to update the service plan with changes in services, care, or treatment.
    - All tenants requiring safety checks will have the frequency of checks addressed on the service plan. Staff have been re-educated on the process for visual checks. Safety checks had been added to staff shift responsibility checklist.
3. How the Program plans to monitor performance to ensure compliance.
    - RN will update on call information as needed.
    - RN will review delegations with staff annually.
    - Tenant charts will be audited every 3 months to assure assessments for change in condition have been completed and service plan reflects needed services, care, and treatment.
    - Safety checks will be audited quarterly to assure completion per tenant's service plan.

4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected by February 10th, 2022.

Service Plans

1. Elements detailing how the Program will correct each regulatory insufficiency
    - Service plans will be completed within 30 days of occupancy.
2. Measures taken to ensure the problem does not recur
    - The Director of Health Services and/or RN Designee will be re-educated on regulatory requirements regarding timing of completion of assessments and service plans.
3. How the Program plans to monitor performance to ensure compliance
    - Ongoing internal audits of tenant charts will be completed at least quarterly to ensure compliance of tenant evaluations and service plans.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected by February10th, 2022.

Staffing

1. Elements detailing how the Program will correct each regulatory insufficiency
    - Tenant #2 service plan has been updated to reflect the frequency of safety checks. Tenant C1 has discharged.
2. Measures taken to ensure the problem does not recur
    - All tenants requiring safety checks will have the frequency of checks addressed on the service plan. Staff have been re-educated on the process for visual checks. Safety checks had been added to staff shift responsibility checklist.
3. How the Program plans to monitor performance to ensure compliance
    - Safety checks will be audited quarterly to assure completion per tenant's service plan.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected by February10th, 2022.