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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 3 Number of tenants with cognitive impairment: 22 Total census: 25 No regulatory insufficiencies were cited during the investigation of Incident #126328-I or Complaint #128060-C. The following regulatory insufficiencies were cited during the investigation of Incident #127434-I and Incident #127435-I.	A 000	See attached POC 7/18/25	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to follow established policies affecting 4 of 7 tenants reviewed. The policy entitled "Abuse, Neglect, and/or Exploitation" affected Tenant 2 and Tenant 3, and the policy entitled "Intimacy" affected Tenant 4 and Tenant 5. Findings follow: Record review on 6/2/25 and 6/3/25 revealed the following: 1) Tenant 2 admitted to the program on 7/14/23 with diagnoses including unspecified dementia of	A 150	The Countryhouse Director of Nursing and the Executive Director will complete a training with all staff at the July 16, 2025, monthly all staff on how to complete an incident report and when to complete mulitiple incident reports. Incident reports will be complete to its entirity by the staff member who responds first to the incident. Med aides will review the incident report or reports prior to the end of their shift for completion. The Leadership team will review incident reports on the next business day and finalize with a nurses note in the chart, incident summary attached, and any updates to the care plan to include proper interventions if needed.	

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unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Tenant 2 had a Global Deterioration Score (GDS) of 6 indicating severe cognitive decline. A service plan dated 9/25/24 identified a history of being destructive/aggressive. It instructed staff to provide cueing and/or intervention to prevent destructive/abusive behavior by recognizing and meeting his possible needs such as being thirsty, hungry, needing to use the bathroom, having pain or being tired. It further instructed staff to communicate with the program med aide to administer medications as appropriate for symptoms and for staff to provide a safe environment by moving him to an area of low stimulation where was few items to be used for destruction or by moving peers away from him. The service plan further identified Tenant 2 had a history of negative interactions with others and required full assistance from staff. Staff were to provide ongoing intervention to avoid negative interactions with other residents.

Tenant 3 admitted to the program on 3/26/24 with diagnoses including Alzheimer's disease with late onset, anxiety disorder, and depression. Tenant 3 had a GDS score of 5 indicating moderately-severe cognitive decline. A service plan identified the tenant was independent with interactions and noted she generally displayed positive interactions with others independently without incident and required no staff assistance.

Two incident reports (one for each tenant) dated 3/18/25 and timed at 7:54 p.m. revealed program staff heard Tenant 3 yelling from her apartment. When staff unlocked and entered Tenant 3's door, Tenant 2 was observed hitting Tenant 3 repeatedly in the face as she sat in her recliner.

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Staff forcefully pushed Tenant 2 off of Tenant 3 while calling out for additional help. Program staff were able to get Tenant 3 to the safety of her bathroom while getting Tenant 2 to leave the room. Staff examined Tenant 3 and found multiple bruises and scratches on her face.

Under the "Response to Incident" section of the incident report for Tenant 2, it indicated Tenant 2's physician was not notified. The form did not indicate if family was notified, but Tenant 2's hospice provider was. Under the "Response to Incident" section of report for Tenant 3, it indicated the physician was notified and lists "no" to the question of whether the family or representative was notified, despite Tenant 3 having indicated she was experiencing pain at a level of 6 and had sustained injuries.

A review of nursing notes for Tenant 2 failed to note the incident on the date of occurrence (3/18/25), but staff had logged symptoms of agitation and restlessness for him at 8:06 p.m., approximately 12 minutes after the initial incident with Tenant 3 on that date. A review of nursing notes for Tenant 3 dated 3/18/25 noted an incident report was created. No further nursing notes were provided which detailed the incident, further assessment of Tenant 3's injuries, or post-incident physical condition or emotional status of the tenant.

A policy entitled "Abuse, Neglect, and/or Exploitation" stated: The Community is committed to providing a safe environment for all residents and staff, within the state-specific regulations. The Community WILL NOT TOLERATE (capitalized and bold font as printed in policy) verbal, mental, sexual, or physical abuse (including corporal punishment or involuntary

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seclusion), neglect, and/or exploitation of any resident by any staff member, other resident, or visitor to the Community.

Included as steps as part of the policy:
Step 4. An Incident Report will be completed.
Step 6. A written summary of the investigation will be prepared, including any changes in the tenant's physical, mental, emotional, and social abilities to cope with the affairs and activities of daily living, physical and mental coordination
In addition to the above, the following items will be done to support the state specific process:
Iowa:
1. Once the Incident Report is completed from step 4 above, a copy of the report will be printed and reviewed to ensure the following items are included along with signatures:
a. Tenant information with relevant history
b. Location and date/time of incident
c. Notification (including date/time of notification) of physician, family and/or designated alternate decision maker
d. Description of incident
e. Contributing factors
f. Preventative measures put in place to ensure safety
g. Assessment of tenant
h. Extent of injury
i. Signature of person completing investigation
j. Review and signature of management

During an interview on 6/3/25 at 12:10 p.m. with the Executive Director, she recalled she and the former program nurse came to the program on the night of the incident to investigate and didn't know if the former nurse completed any further documentation, but believed the former nurse had called Tenant 3's Power of Attorney.

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A 150	Continued From page 4 From the program's provided documentation regarding the incident, there was no evidence a written summary was completed which included the following key elements per the policy: *changes in Tenant 3's physical, mental, emotional, and social abilities to cope with the affairs and activities of daily living, and physical and mental coordination following the incident with Tenant 2. *notification of Tenant 2's physician *notification of Tenant 3's family and/or designated alternate decision-maker *assessment and expected monitoring of the extent of Tenant 3's injuries 2) Tenant 4 admitted to the program 3/14/25 with diagnoses including dementia with agitation. Tenant 4 had a GDS score of 4 indicating moderate cognitive decline. The program provided an unsigned/undated service plan for Tenant 4. A section of the service plan entitled "Interaction" identified he required full assistance from the program and noted a history of negative interactions with others and required ongoing staff intervention to avoid negative interactions with other residents. It further instructed staff to separate Tenant 4 from other residents if he engaged in negative interactions with others, to assist him to an area of quiet and attempt to engage him in a meaningful activity. If staff was unable to redirect Tenant 4, the service plan instructed staff to remove other residents from the area and notify the program nurse of the negative interaction as soon as resident safety was achieved. Tenant 5 admitted to the program on 3/20/23 with diagnoses including unspecified dementia of unspecified severity without behavioral disturbance, psychotic disturbance, mood	A 150		

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disturbance, and anxiety. Tenant 5 had a GDS score of 6 indicating severe cognitive decline. The program provided a service plan dated 9/26/24 for Tenant 5. A section of the service plan entitled "Interaction" noted the tenant enjoyed spending time with a male peer (not named) and that neither she nor the male peer had the capacity to consent to a sexual relationship. The service plan instructed staff to make sure Tenant 5 and the male peer did not go into each other's rooms without staff present. It further instructed staff did not need to discourage Tenant 5 and the male peer from talking or visiting with each other, however, staff needed to be aware of any physical contact (hand holding/kissing) and to gently and calmly redirect both Tenant 5 and the male peer to another activity. Staff were instructed to not say anything to make either person feel badly or like they had done anything wrong and to notify the nurse of any physical contact between the two tenants and interventions.

During staff interviews conducted on 6/3/25, Staff A stated Tenant 5 "liked the males" and was known for often being "very flirtatious" and believed Tenant 4 was her husband. She stated Tenant 4 liked Tenant 5 and was aware of where her apartment was within the program, and described the relationship between Tenant 4 and Tenant 5 as a "love saga." Staff AC stated she didn't feel Tenant 4 likely resisted Tenant 5's advances as Tenant 5 thought of Tenant 4 as her husband and liked him. Staff B stated Tenant 4's behaviors had gotten better since the incident on 3/16/25, but continued to attempt close proximity and stroke others' arms.

An incident report dated 3/16/25 revealed staff went into Tenant 4's room to perform a wellness

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check and observed Tenant 5 sitting in Tenant 4's recliner without pants on and Tenant 4 had his head between the legs of Tenant 5 and was performing oral sex on Tenant 5.

A nursing note dated 3/16/25 at 9:15 p.m. for Tenant 4 following the incident indicated staff immediately intervened and separated Tenant 4 and Tenant 5. A nursing note dated 3/16/25 at 9:30 p.m. for Tenant 5 following the incident indicated Tenant 5 had a red mark on her right breast above her nipple.

The program policy entitled "Intimacy" included the following:
Procedure for Consent in those with a cognitive deficit: If a resident has a GDS of 5 or above, or has indicated cognitive impairment (by diagnosis or other cognitive assessment tool):
1) An Assessment of Consent to Sexual Activity will be completed by a health care professional
2) A Statement of Choice Assessment will be requested from the provider
3) A care conference will be scheduled with the resident and/or representative to discuss outcome of Assessment tools and determine a plan of care
4) The plan of care will be implemented as agreed on during conference
5) Plan of care and interventions will be communicated to employees

During an interview on 6/3/25 at 12:10 p.m. with the Executive Director, she acknowledged the program did not complete the above steps of the policy. While the 3/16/25 incident report for Tenant 4 documented his family representative was notified of the incident and the Executive Director stated she had spoken with the family representatives of Tenant 5, there was no incident

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A 150	Continued From page 7 report completed for Tenant 5 and the Executive Director did not document the discussion. The Executive Director stated a door alarm had been added as an immediate intervention for Tenant 4 so staff would be aware of when he was entering/exiting his room, but no care conference was held based upon the assessments per the program's policy so that a plan of care could be implemented as agreed on by the parties. On 6/4/25 at noon, the Executive Director and Director of Nursing confirmed the above findings for both incidents above.	A 150		
A 385	481-69.26(3)d 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. d. The service plan updated within 30 days of the tenant's occupancy shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to update the service plan within 30 days of the tenant's occupancy and ensure the service plan was signed and dated by all parties for 1 of 1 tenants reviewed admitted in the past three months (Tenant 4.) Findings follow: Record review on 6/2/25 revealed Tenant 4 admitted to the program on 3/14/25. An initial assessment was completed by the program on	A 385	All care plans will be completed timely and care conferences will be scheduled with families to review and sign within 1 week of the completion of the care plan. Upon admission a 24- hour chart review of all new tenants will be completed by the leadership team to verify all required signatures.	

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3/14/25. A section of the initial assessment entitled "Interaction with Others" which assessed the resident's ability to interact in a friendly and appropriate manner with others identified Tenant 4 was independent with his interactions and noted Tenant 4 displayed positive interactions with others without incident and required no staff assistance.

A 30-day assessment for Tenant 4 was dated 4/10/25. The 30-day assessment identified a change in Tenant 4's identified needs in the area of Interaction with Others and identified Tenant 4 required Full Assistance of program staff and noted Tenant 4 had a history of negative interactions with others and required ongoing staff intervention. The service plan instructed staff to provide ongoing intervention to avoid negative interactions with other residents. It further instructed staff if Tenant 4 was engaged in a negative interaction to separate Tenant 4 from other residents, to assist Tenant 4 to an area of quiet and attempt to engage Tenant 4 in a meaningful activity. If staff was unable to redirect Tenant 4, the service plan instructed staff to remove other residents from the area and notify the program nurse of the negative interaction as soon as resident safety was achieved.

The program provided an unsigned/undated service plan which further verified the change of needs in the area of Tenant 4's interactions.

During an interview on 6/4/25 at 10:51 am the Executive Director confirmed no service plan could be located that was signed and dated by all parties at the time of Tenant 4's initial admission or 30-day assessment.

On 6/4/25 at noon, the Executive Director and

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A 385	Continued From page 9 Director of Nursing confirmed the above finding.	A 385		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure service plans were individualized and identified tenants' needs for 2 of 7 tenants reviewed (Tenant 2 and Tenant 4). Findings follow: Record review 6/2/25 to 6/3/25 revealed: 1) A service plan dated 9/24/24 signed by all parties identified Tenant 2 required hospice care services. A nursing note dated 4/22/25 revealed Tenant 2 was discharged from hospice services due to no longer meeting hospice criteria. The program provided an unsigned/undated service plan which continued to state Tenant 2 required hospice care services. During an interview on 6/4/25 the Executive Director acknowledged the current service plan for Tenant 2 incorrectly identified the tenant remained on hospice services and had not been updated at the time of discontinuation of hospice services. 2) The program provided an unsigned/undated	A 395	The Director of Nursing will update all individualized care plans with correct verbiage when a change of condition occurs and also enter a nursing note identifying the changes. The Leadership team will review the updated care plan changes within the next business day for completion. The Executive Director and Director of Nursing will schedule care conferences with Families to discuss changes and sign new care plans as needed.	

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service plan for Tenant 4. A section of the service plan entitled "Interaction" identified he required full assistance from the program and noted a history of negative interactions with others and required ongoing staff intervention to avoid negative interactions with other residents. It further instructed staff to separate Tenant 4 from other residents if he engaged in negative interactions with others, to assist him to an area of quiet and attempt to engage him in a meaningful activity. If staff was unable to redirect Tenant 4, the service plan instructed staff to remove other residents from the area and notify the program nurse of the negative interaction as soon as resident safety was achieved.

An incident report dated 3/16/25 revealed staff went into Tenant 4's room to perform a wellness check and observed a female tenant sitting in Tenant 4's recliner without pants on. Tenant 4 had his head between the legs of female tenant performing oral sex. A nursing note dated 3/16/25 at 9:15 pm for Tenant 4 following the incident indicated staff immediately intervened and separated Tenant 4 and the other tenant.

During an interview on 6/3/25 at 12:10 pm the Executive Director stated a door alarm had been added as an immediate intervention for Tenant 4 so staff would be aware of when he was entering/exiting his room. She acknowledged the service plan was not updated following the sexual incident and did not include the addition of the alarm on his apartment door.

On 6/4/25 at Noon, the Executive Director and Director of Nursing confirmed the above findings.