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
	16427_hfd	A. BUILDING: _____ B. WING _____	C 10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	**5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411**

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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. Tenants without cognitive disorder: 7 Tenants with cognitive disorder: 27 Total Census: 34 No regulatory insufficiencies were cited during the investigation of Complaint #129783-C. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program.	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 and treatments as ordered. This pertained to 3 of 4 sample tenants related to medication administration (Tenant #1, Tenant #3, and Tenant	A 285		

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A 285	Continued From page 1 #5). Findings follow: 1. Record review on 10/13/25 of Tenant #1's file revealed staff administered his medications. Continued record review revealed the August 2025 Medication Administration Record (MAR), recorded 11 times Tenant #1's medication was not available for administration. The medication included acetaminophen 325 milligram (mg) tablet, Senna-time 8.6 mg tablet, potassium CL ER 20 milliequivalents, melatonin 5 mg tablet and citalopram Hbr 20 mg tablet. 2. Record review on 10/13/25 and 10/14/25 of Tenant #3's file revealed staff administered her medications. Continued record review revealed a Medication Error Report, dated 9/24/25 indicated the dates of the error were 8/6/25 to 9/24/25. The medication ordered was insulin-Lantus 10 units, once daily in the p.m. The report noted she received 10 units of Lantus at 8:00 a.m. and the ordered dose at 8:00 p.m. The report indicated she had no issues and continued to have high blood glucose levels. Her primary care provider (PCP) and family were notified. The PCP instructed to double check the dose to verify time and dose. The report noted a wrong time error with the reason as a transcription error. Pharmacy was contacted to adjust the time to 8:00 p.m. only in the electronic system. Pharmacy entered the Lantus order twice, one order from the prior PCP and the other order from the new PCP. The report noted the person making the error was "many med aides." Continued record review revealed upon admission Tenant #3 had an order for insulin glargine, Lantus Solostar Pen 100 units/milliliters	A 285		

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A 285	Continued From page 2 (ml), inject 10 units, subcutaneous every night at bedtime. An order dated 7/18/25 directed to complete the blood glucose monitoring twice daily. Further record review revealed an order dated 8/0/25, noted to start Lantus 10 units once daily. Another order received on 8/01/25, directed to check fasting blood glucose once daily. Continued record review revealed the August and September 2025 medication administration records (MARs) reflected administration of Lantus 10 units at 8:00 p.m. from 8/01/25 to 8/31/25 and 9/01/25 to 9/30/25. The MARs also reflected an order for Lantus Solostar 10 units at 8:00 a.m. The 8:00 a.m. Lantus Solostart 10 units reflected on the MAR as administered from 8/06/25 to 8/31/25 and from 9/01/25 to 9/24/25. Additionally, the August, September and October MARs reflected blood glucose monitoring twice daily and not once daily as ordered on 8/01/25. 3. Record review on 10/14/25 of Tenant #5's file revealed she received hospice services and staff administered her medications. An order found, dated 11/06/24, directed to leave the right heel open to air, continue with Prafo boots when heels were not off loaded. Apply betadine to the left heel daily and leave open to air, continued with Prafo boots when heels were not off loaded. Continued record review revealed a Medication Profile reflected an order dated 12/19/24 to apply one pad Betadine 10% topical pad, daily, use one wipe/pad each to left and right heel daily for bilateral heel wounds. A Hospice document indicated an order to apply betadine to a one by one centimeter (cm) blister on the right bunion daily. Leave open to air and to continue with	A 285		

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A 285	Continued From page 3 Prafo boots when heels were not offloaded dated 1/16/25. Further record review revealed the August to October 2025 MARs failed to reflect the application of the physician ordered Prafo boots. The August to October 2025 treatment administration records (TARs) also failed to reflect the order or completion of the physician ordered treatment. Continued record review revealed the August to October 2025 TARs reflected staff completed a right great toe dressing change once daily at 8:00 a.m. The August to October TARs reflected over 10 times the treatment failed to be completed as ordered. The staff either charted the toe was healed of the treatment not done per the nurse. Additionally, the TARs did not reflect the order indicated above for the bilateral heel wounds. When interviewed on 10/14/25 at 3:15 p.m. the Director of Nursing (DON) explained , if Tenant #5's toe wound was not open, staff did not put betadine on it. She reported the wound was currently closed. The DON confirmed all MARs and orders were provided for the tenants reviewed.	A 285		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall	A 145		

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A 145	Continued From page 4	A 145		

be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 1 of 3 sample tenants receiving hospice services (Tenant #4). Finding follows:

Record review on 10/14/25 of Tenant #4's current service plan dated 8/26/25, indicated Tenant #4 admitted into hospice. She required the assistance of two staff and a gait belt for all transfers.

When interviewed on 10/14/25 at 3:15 p.m. the Director of Nursing (DON) indicated when Tenant #4 came back from the hospital and started on hospice she required the assistance of two staff for about a week. She explained Tenant #4 currently required the assistance of one person and a gait belt for transfers.

Continued record review revealed cognitive, health and functional evaluations were most recently completed on 8/26/25. The evaluation noted the emergency department (ED) evaluated her on 8/24/25 for a stroke and the family elected for comfort measures. The evaluation determined she required the assistance of two at that time for

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A 145	Continued From page 5 toileting and bathing. Further record review revealed evaluations were not completed with significant change when Tenant #4 no longer required the assistance of two staff for transfers. When interviewed on 10/14/25 at 3:15 p.m. the DON confirmed all evaluations were provided for the tenants reviewed.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 3 of 6 sample tenants (Tenant, #1, Tenant #4 and Tenant #5). Findings follow: 1. Record review on 10/13/25 revealed Tenant #1's Observations (nurse's notes), dated 5/12/25 noted Tenant #1 returned from his overnight stay at the hospital. He had a cut on the back of his head and it was glued. Continued record review revealed an incident	A 290		

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report dated 5/11/25 indicated at 4:40 p.m. Tenant #1 experienced an unwitnessed fall. Staff found Tenant #1 on the floor, holding his head with blood on the floor. Staff placed gauze on the wound, called 911 and notified the nurse on-call. Tenant #1 went to the emergency department (ED).

Further record review revealed a nurse's note failed to be documented when Tenant #1 was sent to the ED.

2. Record review on 10/13/25 and 10/14/25 of Tenant #4's file revealed Observations (nurse's notes) noted the following:

On 8/11/2,staff reported Tenant #4 woke up with a bloody nose at 8:00 a.m. Staff was instructed to check her blood pressure and read 221/111. Staff was instructed to hold the bridge of her nose and recheck her blood pressure in one hour. Her rechecked blood pressure read at 241/92. Staff was instructed to complete a manual blood pressure and it showed 170/90. The primary care provider's (PCP) nurse was informed about the elevated blood pressure and bloody nose.

On 8/24/25, Tenant #4 was evaluated in the ED. Her family took Tenant #4 from the Program via private vehicle.

On 8/26/25, Tenant #1 admitted into hospice following a stroke on 8/24/25.

Continued record review revealed nurse's notes failed to be documented by exception related to the follow up to the bloody nose and elevated blood pressure on 8/11/25. Additionally, a note failed to be completed related to why Tenant #4 was taken to the ED or when she returned to the

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A 290	Continued From page 7 Program. 3. Record review on 10/14/25 revealed Tenant #5's Observations (nurse's notes) noted on 9/24/25, Tenant #5 removed her protective boots and in pain from the bunion on her right great toe. Tenant #5 showed a little pain. The sock was removed to take the pressure off of her toe. Continued record review revealed a follow up note failed to be completed related Tenant #5 removing her protective boots and the pain reported on her right great toe. When interviewed on 10/14/25 at 3:15 p.m. the Director of Nursing confirmed all nurse's notes were provided for the tenants reviewed.	A 290		
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 as needed and failed to ensure service plans reflected the service needs of tenants. This pertained to 6 of 6	A 350		

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A 350	Continued From page 8 sample tenants (Tenant #1, Tenant #2, Tenant #3, Tenant #4, Tenant #5 and Tenant #6). Findings follow: 1. Record review on 10/13/25 revealed Tenant #1's Observations (nurse's notes) noted the following: On 4/30/25, Tenant #1 experienced an unwitnessed fall. On 5/8/25, Tenant #1 experienced an unwitnessed fall. On 5/11/25, Tenant #1 became agitated and chased two staff around the dining room and kicked another tenant's walker. On 5/11/25, Tenant #1 experienced an unwitnessed fall. On 6/27/25, Tenant #1's legs were edematous. Staff were reminded to apply Tubigrip as ordered. Staff should apply Tubigrip daily to keep his swelling down. On 7/12/25, Tenant #1 was observed on the floor. On 7/19/25, Tenant #1 experienced a witnessed fall. On 7/24/25, Tenant #1 experienced an unwitnessed fall. On 8/15/25, Tenant #1 raised his fist at staff before he realized staff was there to change his soiled sheets. He finally allowed staff to change him and the bedding. On 8/15/25, Tenant #1 experienced an	A 350		

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unwitnessed fall.

On 8/30/25, Tenant #1 experienced an unwitnessed fall.

On 9/05/25, Tenant #1 was agitated and not following directions. He was incontinent of urine. He was upset and would not let staff change him.

On 9/06/25, Tenant #1 came up behind staff, started to yell and used profanity when staff did not give him the medication computer. Later, he took a chemical bottle and washcloth out of the staff's hands when they were talking. He initially refused to give it back but eventually gave it back.

On 9/8/25, Tenant #1 wrote on table mats and staff asked him for the pen. Staff asked again and he swatted at the staff. When staff attempted to remove the mats he tried to swing and hit staff's hand with his fist. Another staff responded,Tenant #1 grabbed and hit that staff.

On 9/9/25, Tenant #1's behaviors were discussed with the hospice nurse. The behaviors escalated to being physical and not redirectable. New medications and adjustments were ordered.

On 9/10/25, Tenant #1 experienced a witnessed fall.

Continued record review revealed Tenant #1's service plan reflected he had falls but failed to include fall interventions. The service plan also failed to be updated to include behaviors as noted in the observation notes above and interventions related to the behaviors.

2. Record review on 10/13/25 revealed Tenant #2's Observations (nurse's notes) noted the

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following:

On 8/13/25, four staff assisted Tenant #2 getting back in bed due to soiled bedding. When staff assisted him, he stopped using his legs to walk or his hands to hold his walker. After several prompts he made it back to bed safely.

On 8/13/25, Tenant #2 had redness noticed on both sides of his groin/upper thigh. A cream was applied and the nurse was notified.

On 8/22/25, Tenant #2 had some chaffed skin on his testicles. The area was cleansed with bath wipes and barrier cream applied.

On 8/24/25, Tenant #2 refused to get up for staff to toilet him. He required the assistance of three staff with transferring him from the dining room chair, to the wheelchair and to his chair in the room. When in the room he refused to get up from the wheelchair. Staff were able to get him up but he swung his walker into one of the staff. Staff were able to get him changed and into the chair safely.

On 9/9/2, staff tried three times to get Tenant #2 up to use the bathroom and he refused. Staff continued to try and notify the on-coming shift.

On 9/25/25, Tenant #2 told dietary staff he was going to stab her when staff asked if she could take his plate. Tenant #2 picked up his fort and tried to stab her.

On 10/04/25, Tenant #2 was done with breakfast, the staff tried to take his dishes and he told staff he was going to stab them.

On 10/08/25, staff tried to help Tenant #2 go to

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the bathroom. He put his arm up in a fist and said he was going to hit the staff.

Continued record review revealed Tenant #2's service plan dated 7/27/25 indicated staff assisted with toileting every two hours and as needed. The plan indicated he had short term memory loss and could become agitated if he did not understand expectations. The service plan failed to be updated to reflect the behaviors as noted above.

3. Record review on 10/13/25 and 10/14/25 revealed Tenant #3's Observations (nurse's notes) noted the following:

On 7/20/25, Tenant #3 went into other tenant's apartments and tried to help the tenants with toileting or changing clothes.

On 7/22/25, Tenant #3 indicated she wished she could use a small gun with one bullet to take it all away.

On 7/22/25, Tenant #3 attempted to go to the exit doors and said she was going to exit through a window.

On 7/25/25, Tenant #3 was tearful and told people goodbye.

On 7/27/25, Tenant #3 was up all night and tried to get into other tenant apartments.

On 7/27/25, Tenant #3 would not leave Tenant #6 alone and kept trying to kiss him when his head was down on the table.

On 8/15/25, she continued to walk up to male tenants and tried to kiss them.

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A 350	Continued From page 12 On 8/19/25, Tenant #3 had been redirected to stay in her own personal space and not to kiss people or help them in the bathrooms. On 8/21/25, staff found Tenant #3 in another tenant's bed (Tenant #6). When she would not leave the other tenant got upset, he grabbed her by the arms and threatened to choke her if she did not leave. On 8/23/25, sent a fax to the PCP to request an as needed medication due to behaviors, manic episodes and repeatedly touching other tenants. On 8/24/25, Tenant #3 kissed another tenant and verbally redirected. On 8/25/25, she put her protective undergarment in the garbage with clothing, put clothing in the sink and then urinated on the floor, which left a trail from the bathroom to the bed. On 8/27/25, Tenant #3 kissed a male tenant on the mouth in front of the tenant's spouse, which upset the spouse. She was redirected to stay in her own space. On 8/28/25, Tenant #3 kissed another male tenant on the mouth. On 9/5/25, Tenant #3 had to be redirected twice while the male tenant's spouse was there. On 9/15/25, Tenant #3 observed kissing a male tenant. On 9/25/25, Tenant #3 hit dietary staff with a tray after being directed not to pick up cups and trays.	A 350		

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A 350	Continued From page 13 Continued record review revealed Tenant #3's service plan failed to reflect the behaviors as indicated above and interventions for her behaviors. 4. Record review on 10/13/25 and 10/14/25 revealed Tenant #4's Observations (nurse's notes) noted the following: On 8/11/25, staff reported Tenant #4 woke up with a bloody nose at 8:00 a.m. Staff was instructed to check her blood pressure (BP) and it read 221/111. Staff was instructed to hold the bridge of her nose and recheck her BP in one hour. The BP rechecked at 241/92. Staff was instructed to complete a manual blood pressure and the BP showed 170/90. The primary care provider's (PCP) nurse was informed about the elevated BP and bloody nose. On 8/24/25, Tenant #4 was evaluated in the ED. Her family took her from the Program via private vehicle. On 8/26/25, Tenant #4 admitted to hospice following a stroke on 8/24/25. On 8/28/25, ordered a hospital bed for Tenant #4. On 9/12/25, Tenant #4's family member came to the front door, tried to enter, and staff turned them away. The family member would not leave and police were called. On 10/06/25, Tenant #4 showed high blood pressure when read at 212/100 and then 190/102. Staff to monitor if she became symptomatic. Continued record review revealed Tenant #4's	A 350		

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	16427_hfd	A. BUILDING: _____ B. WING _____	C 10/14/2025

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A 350	Continued From page 14 service plan dated 8/26/25, failed to reflect the hypertensive episodes as noted above, including one with a bloody nose. It also failed to reflect any visitor restrictions with family or the hospital bed. 5. Record review on 10/14/25 revealed Tenant #5's Observations (nurse's notes) noted on 9/23/25, Tenant #5 required full staff assistance with eating breakfast and lunch the last three days. When she had the utensil she moved the food around and flattened it but did not eat it. She consumed the entire meal when staff fed her. Continued record review revealed hospice documents indicated hospice provided a hospital bed with half rails, mattress, low air loss pump and pad, gel cushion and Broda wheelchair. Hospice documents indicated to place the Prafo boots on when up in the chair, wheelchair or laying in bed. A Medication Profile reflected an order dated 12/19/24 to apply one pad Betadine 10% topical pad, daily, use one wipe/pad each to left and right heel daily for bilateral heel wounds. A Hospice document, dated 1/16/25 indicated an order to apply betadine to the one by one centimeter (cm) blister on her right bunion daily. Leave open to air and to continue with profo boots when heels were not offloaded. Further record review revealed Tenant #5's service plan failed to reflect the eating assistance at times as indicated above, the hospital bed with low air loss pump and the pad and gel cushion. The service plan directed to have the Prafo boots on while in the Broda chair but failed to include when in the recliner or laying in bed. Additionally, the service plan failed to reflect the affected areas on her feet and the treatment ordered as noted above.	A 350		

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A 350	Continued From page 15 6. Record review on 10/13/25 and 10/14/25 revealed Tenant #6's Observations (nurse's notes) noted the following: On 7/27/25, Tenant #6 yelled at another tenant. On 7/27/25, he slept at the table. When staff asked him if he wanted to go to his apartment and staff moved his chair. Tenant #6, raised his head and fist at the staff and told staff if they touched him again he would hit staff in the face. On 8/20/25, Tenant #6 was involved in a verbal altercation with another tenant. On 8/21/25, Tenant #6 got upset as staff attempted to help him with a shower. He swung his fists at staff. On 8/21/25, Tenant #6 asked what apartment was his and staff walked with him. When the door opened a female tenant sat on his bed. Staff removed her from the apartment and he hit her on the back. On 8/21/25, staff found another tenant in Tenant #6's bed. When staff tried to get the other tenant out, Tenant #6 got upset and aggressive with the other tenant. He grabbed her by the arms and threatened to choke her if she did not leave. On 8/27/25, Tenant #6 used profanity towards a staff. On 9/12/25, Tenant #6 yelled at another staff for tapping on the table. Tenant #6 told the other tenant he was going to harm him. On 9/23/25, Tenant #6 ate off of other tenant's plates. When staff redirected, he raised his voice	A 350		

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A 350	Continued From page 16 and swore at staff. On 10/2/25, due to his behaviors the PCP changed his medications. Continued record review revealed Tenant #6's service plan, dated 7/21/25 indicated Tenant #6 occasionally needed redirection when talking to others. The service plan failed to reflect the behaviors in the service plans as indicated above. When interviewed on 10/14/25 3:15 p.m. the DON confirmed all service plans were provided for the tenants reviewed.	A 350		
A 370	481-69.26(3)a Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain a signed service plan when a significant change occurred. This pertained to 1 of 3 sample tenants receiving hospice services (Tenant #4). Finding follows: Record review on 10/14/25 revealed Tenant #4's Observations (nurse's notes) noted the following:	A 370		

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A 370	Continued From page 17 On 8/24/25, the emergency department (ED) evaluated Tenant #4. Her family took her from the Program via private vehicle. On 8/26/25, she admitted to hospice following a stroke on 8/24/25. Continued record review revealed cognitive, health and functional evaluations completed on 8/26/25. The evaluation indicated she was evaluated in the ED on 8/24/25 for a stroke and family elected for comfort measures. The evaluation determined she required the assistance of two at that time for toileting and bathing. Further record review revealed a current service plan (date printed on 10/14/25) reflected hospice care and increased care needs; however, a signed updated service plan was not found related to the significant change in services. When interviewed on 10/14/25 at 3:15 p.m. the Director of Nursing confirmed all signed service plans were provided for the tenants reviewed.	A 370		
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.	A 385		

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A 385	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain a signed service plan within 30 days of taking occupancy. This pertained of 1 of 1 sample tenants admitted in the last four months (Tenant #3). Finding follows: Record review on 10/13/25 and 10/24/25 of Tenant #3's file revealed she was admitted on 7/08/25. An initial service plan was dated 7/08/25. Tenant #3's cognitive, health and functional evaluations were completed on 8/08/25 (30 day evaluations); however, a signed service plan failed to be completed within 30 days of taking occupancy. When interviewed on 10/14/25 at 3:39 p.m. the Executive Director confirmed all service plans were provided for the tenants reviewed.	A 385		
A 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by:	A 430		

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A 430	Continued From page 19 Based on interview and record review the Program failed to complete nurse reviews as needed. This pertained to 1 of 1 sample tenant with a documented medication error (Tenant #3). Finding follows: Record review on 10/13/25 and 10/14/25 of Tenant #3's file revealed staff administered her medications. A Medication Error Report dated 9/24/25, indicated the dates of the error were from 8/06/25 to 9/24/25. The medication ordered was insulin-Lantus 10 units, once daily in the p.m. The report indicated she received 10 units of Lantus at 8:00 a.m. and the ordered dose at 8:00 p.m. The report indicated she had no issues and continued to have high blood glucose levels. Her primary care provider (PCP) and family were notified. The PCP instructions indicated to double check the dose to verify time and dose. The type of error noted the wrong time and the reason was a transcription error. Pharmacy was contacted for the time adjustment to 8:00 p.m. in the electronic system. Pharmacy entered the Lantus twice, one from an order with the prior PCP and one from the new PCP. The report noted the person making the error was "many med aides." Continued record review revealed upon admission Tenant #3's order for insulin glargine, Lantus Solostar Pen 100 units/milliliters (ml), inject 10 units, subcutaneous every night at bedtime. An order received on 8/01/25, noted on 8/04/25 to start Lantus 10 units once daily. Further record review revealed the August and September 2025 medication administration records (MARs) reflected an order for Lantus 10 units at 8:00 p.m. administered from 8/01/25 to	A 430		

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A 430	Continued From page 20 8/31/25 and 9/01/25 to 9/30/25. The MARs also reflected an order for Lantus Solostar 10 units at 8:00 a.m. From 8/06/25 to 8/31/25 and 9/01/25 to 9/24/25 the MAR documented the administration of the Lantus Solostar at 8:00 a.m. A nurse review failed to be documented for the medication error that occurred from 8/06/25 to 9/24/25 regarding Tenant #3's insulin. Additionally, a nurse's note or entry failed to be found related to medication error. When interviewed on 10/14/25 at 3:15 p.m. the Director of Nursing indicated she spoke with the nurse at the PCP's office and was made aware. She was instructed to verify the correct dose. She said she put a note in about it when it happened to follow up.	A 430		