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
	S0375	A. BUILDING: _____ B. WING _____	C 11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE ALPD	3 RUSSELL SLADE BLVD CORALVILLE, IA 52241

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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 impairment: 3 Tenants with cognitive impairment: 30 Total census: 33 The following regulatory insufficiencies were cited related to the investigation of Complaint #130037-C, Incident #130046-I and the recertification visit conducted to determine compliance with certification a Dedicated Dementia Specific Assisted Living Program:	A 000	See attached POC 2/28/26	
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 policy and procedure related to incident reports. This pertained to 1 of 1 tenant reviewed with a documented medication error (Tenant #2) and potentially affected all tenants (census of 33). Findings follow: 1. Record review on 11/03/25 of incident reports revealed an Incident Report in the new electronic system for Tenant #2, dated 11/03/25 indicated at 8:23 a.m. there was a medication variance-incorrect dosage. The description indicated syringes contained 0.5 milliliters (ml)	A 150		

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

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A 150	Continued From page 1	A 150		

and the correct morphine dosage was 0.25 ml. The incident report reflected vitals signs and indicated the primary care provider (PCP) was notified on 8/18/25 and Tenant #2's family member was notified on 8/19/25. The Wellness Director completed the report on 8/18/25 at 8:29 p.m. The incident report also reflected the electronic signature of the Executive Director without a date or time noted. The incident report reflected a discrepancy in dates. It also did not reflect the number of syringes incorrectly filled and how many were administered.

When interviewed on 11/10/25 at 10:58 a.m. the Wellness Director indicated syringes for Tenant #2 were filled with the wrong dose. She did not know how many syringes were administered. The syringes were filled with double the dose. It was discovered when the Wellness Director went to fill the syringes (set up by the Former Assistant Wellness Director). She reported the Program no longer filled syringes, they were set up by the pharmacy for all narcotics.

2. Record review on 11/03/25 of incident reports revealed three different formats provided as noted below:

a. Incident reports dated 8/04/25 and 8/08/25 were provided from the prior electronic records system. The next incident report provided was dated 9/19/25. There were no other incidents documented from 8/08/25 to 9/19/25.

b. Nine handwritten Resident Incident Reports were provided for incidents from 9/19/25 to 10/05/25. Seven incident reports reflected incomplete vitals recorded or no recorded vitals. There were no incident reports provided from 10/05/25 to 10/15/25.

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A 150	Continued From page 2 c. The current electronic records system included 15 incident reports from 10/15/25 to 11/03/25. Nine incident reports reflected no vitals record or an incomplete set of vitals recorded. 3. Continued record review revealed the Program's policy and procedure for incident reports, dated 8/15/25, directed staff to take the tenant's blood pressure, pulse, respiration and temperature for every incident. The shift supervisor was responsible for completing the incident report in the online electronic reporting system within two hours of the incident. The incident report should be fully completed and reflect how, when, and where the incident occurred. Incident reports entered into the online electronic incident platform were an internal document and were not to be "shared, disseminated, or distributed to anyone including but not limited to resident, family, Power of Attorney, state agency, or other legal entity." When interviewed on 11/10/25 at 10:58 a.m. the Wellness Director indicated incident reports should be completed within 72 hours of the incident and vitals should be recorded. When interviewed on 11/06/25 at 2:13 p.m. the Executive Director reported the vitals were directed by the nurse when vitals needed completed and done timely. She confirmed incident reports were to be filled out before the end of shift.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights:	A 160		

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A 160	Continued From page 3 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, treatments and care to tenants. This pertained to 4 of 7 current tenants (Tenants #1, #3, #6 and #7). Findings follow: 1. During an interview on 11/05/25 Tenant #7 indicated housekeeping should occur weekly; however, it occurred 50% of the time. She reported hair in the shower. She reported laundry was twice weekly and there were baskets missing; however, laundry had improved. She explained there were three groups of staff in the building: the staff with the management company and two staffing agencies, which provided staff daily. Tenant #7 expressed concern about different people and not knowing the tenants' routines with various agencies. She explained the Program looked for another registered nurse (for the building) and a licensed practical nurse for the memory care units. She voiced it was a big job for the Wellness Director. During an interview on 11/06/25 at 11:08 a.m. Tenant #1's family voiced concerns with a lack of nursing follow up. She expressed concern with turnover of staff and use of agency staff at the Program, which she felt were not invested in tenants' care. She indicated the tenant (her family	A 160		

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member) needed help (reminders) with showers, toileting and hygiene (brushing his teeth). The staffs' phone and care plan did not reflect it; it reflected he was independent, however he was not and needed assistance. She followed up with the Unit Program Director, who went to nursing and nothing happened. She reported his shaving was terrible, but had improved. On 9/17/25 the bottom sheet on his bed was soiled with feces, the Unit Program Director was asked to come and she changed it. On 9/28/25 his comforter was soiled with feces and was put soiled side down on his bed. On 10/08/25 there was no bottom sheet and his soiled comforter with (feces) was on his recliner. She visited with the staff who reported he was incontinent and slept on the mattress pad. She explained there were other linens available in his room with a sign on where to find them. Staff mentioned the big washing machine was occupied (related to the comforter) and they brought it back (soiled)to his room until it was available. Yesterday she found a sock in his closet with feces on it. She explained regarding housekeeping behind his dresser there was a bunch of stuff not swept. Previously there were issues with his toilet, cleanliness in the bathroom but it was good now.

During an interview on 11/06/25 at 3:45 p.m. Tenant #6's family member indicated a problem with nursing at the building. The family member thought the tenant's (her family member) clothes had not been changed from 10/26/25 to 11/05/25. She did not feel all staff had the experience to get things done. She reported today at a doctor's appointment the tenant was brought dressed in a dirty shirt and shorts. The tenant showered the day before, but she was unsure about the last shower and, when asked, no one knew. The family was asked to get an air purifier for the

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tenant's apartment due to odor but she noted staff did not clean up around where the tenant sat. Laundry was supposed to be completed weekly and his pants were missing. She recalled recently there was another tenant out in the common area making noise and it was determined the other tenant needed to use the bathroom. Activity staff assisted him to the apartment (there were no direct care staff out); however, did not assist him with the task and he returned to the common area incontinent of urine.

When interviewed on 11/03/25 at 2:11 p.m. Staff D indicated agency staff misplaced laundry items and sometimes items were put in other tenants' apartments, though it did not happen too often. Staff D explained for the most part tenants received services according to their plan. There were agency staff who did not want to work. She indicated this occurred once or twice per week on the first shift related to toileting. When Staff D observed this, she went ahead and did it.

When interviewed on 11/05/25 at 11:43 a.m. the Unit Program Director explained the wandering laundry items and the lost items recently occurred more frequently than not. It was recommended to label items. She reported housekeeping was scheduled once per week and staff also cleaned up. The intention was to complete housekeeping as scheduled, but sometimes it occurred on a different day due to staffing. In the past, Tenant #3's apartment frequently had the bathroom to be cleaned up after an accident. She indicated it occurred pretty frequently as Tenant #3 had more accidents. She reported Tenant #3 refused bathing 80 percent (%) of the time.

2. Record review on 11/04/25 and 11/05/25 of Tenant #1's file revealed the Recorded Care

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A 160	Continued From page 6 Report reflected bed making assistance, compression hose and garbage removal. Tenant #1's service plan dated 4/10/25, reflected assistance including Tenant #1 needed physical assistance with bathing twice weekly, assistance with compression hose, cueing and standby assistance for grooming, medication administration, supervision of CPAP to ensure its on when in the bed or recliner and a physical assist with toileting. The tasks of bathing, grooming, medication administration, CPAP and toileting were not reflected on the recorded cares completed by staff. The Recorded Care Report were the tasks assigned for staff to complete. Record review on 11/06/25 of Tenant #3's file revealed the Recorded Care Report reflected scheduled tasks that were documented as not completed from 10/01/25 to 10/30/25. Those tasks included: garbage removal, grooming/hygiene assistance, incontinence assistance, mobility/transfer assistance, oral hygiene assistance, bed making assistance, dressing assistance. The dates tasks were charted as not completed included: 10/03/25, 10/09/25, 10/11/25, 10/14/25, 10/19/25, 10/23/25, 10/25/25, 10/30/25. Record review on 11/10/25 of Tenant #6's file revealed the service plan failed to reflect Tenant #6 needed assistance with dressing or toileting. The Recorded Care Report also failed to reflect the assistance of dressing or toileting assistance (see interview above related to needing assistance with dressing). 3. When interviewed on 11/06/25 at 2:13 p.m. and on 11/10/25 at approximately 1:22 p.m. the Executive Director indicated cleaning was completed once per week and as needed. She	A 160		

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A 160	Continued From page 7 said there were two new housekeepers. The Executive Director reported tenants received services as indicated on service plans, intermittent things here or there were addressed right away. She indicated at the time of the exit interview there had been no reports made (related to the above interviews) and there were no witnesses.	A 160		
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 as ordered. This pertained to 4 of 6 current tenants reviewed (Tenants #1, #2, #5, and #6). Findings follow: 1. Record review on 11/04/25 and 11/05/25 revealed Tenant #1's August 2025 medication administration records (MARs) reflected staff were not able to administer the following medication: a. On 8/11/25 at 8:00 a.m. trazodone 50 milligram (mg) tablet, noted a refill needed.	A 285		

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A 285	Continued From page 8 b. On 8/12/25 at 8:00 a.m. trazodone 50 mg tablet, noted a refill needed. c. On 8/15/25 at 8:00 a.m. trazodone 50 mg tablet, noted the medication was not available and backordered. d. On 8/17/25 at 8:00 p.m. melatonin 3 mg tablet, noted the medication was not located. e. On 9/30/25 at 4:30 p.m. atorvastatin 40 mg tablet, noted not available. f. On 9/30/25 at 4:30 p.m. metformin 500 mg ER tablet, noted not available. g. On 9/30/25 at 4:30 p.m. sertraline 50 mg tablet, noted not available. h. On 9/30/25 at 4:30 p.m. Xarelto 20 mg tablet, noted not available. 2. Record review on 11/05/25 revealed Tenant #2's Incident Report, dated 11/03/25, noted at 8:23 a.m. a medication variance-incorrect dosage. The report indicated syringes contained 0.5 milliliters (ml) and the correct morphine dosage was 0.25 ml. The incident report reflected vitals signs and indicated the primary care provider (PCP) was notified on 8/18/25 and Tenant #2's family member was notified on 8/19/25. When interviewed on 11/10/25 at 10:58 a.m. the Wellness Director confirmed syringes for Tenant #2 were filled with double the ordered dose. She did not know how many syringes were administered. It was discovered when the Wellness Director went to fill the syringes.	A 285		

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A 285	Continued From page 9 A picture provided by the program showed three syringes and plastic bag with Tenant #2's name, date of 8/06/25 and the medication lorazepam (not morphine as indicated in the incident report). The syringes in the picture appeared drawn up at 0.5 ml. A medication error report or incident report was not provided related to an error with Tenant #2's lorazepam; however, the dosing at that time for lorazepam both scheduled and as needed was 0.25 ml (0.5 mg) and 0.5 ml was not reflected on the orders or MARs. Continued record review revealed orders were received dated 8/04/25 (noted on 8/06/25). The orders included the following: a. Discontinue lorazepam 2 mg/1 ml oral concentrate, 0.5 mg (0.25 ml) by mouth every four hours b. Discontinue morphine 100 mg/5 ml (20 mg/1 ml) oral concentrate give 5 mg by mouth twice daily c. Start lorazepam 2 mg/1 ml oral concentrate, 0.5 mg (0.25 ml) by mouth twice daily d. Start lorazepam 2 mg/1 ml oral concentrate, 0.5 mg (0.25 ml) by mouth every four hours as needed for restlessness/anxiety e. Start morphine 100 mg/5 ml (20 mg/1 ml) oral concentrate, 5 mg (0.25 ml) by mouth three times per day f. Continue morphine 100/5 ml (20 mg/1 ml) oral concentrate, 0.5 mg (0.25 ml) by mouth every four hours as needed for pain.	A 285		

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Further record review revealed Tenant #2's August 2025 MAR reflected an order for morphine sulfate 2 mg/ml 0.25 ml by mouth three times per day starting on 8/06/25. Staff initialed for the administration of the medication from 8/06/25 to 8/15/25. The MAR indicated the order was discontinued on 8/16/25 due to duplication and should not be scheduled routinely with a pain patch. The MAR reflected an order on 8/18/25 for morphine sulfate 100/5 ml, one syringe filled with 0.25 ml (5 mg) by mouth every four hours as needed.

The MAR in the prior electronic records system also reflected the order for lorazepam 2 mg/ml solution, 0.25 ml by mouth twice daily was administered from 8/06/25 to 8/16/25. The MAR in the current electronic system reflected the order for lorazepam to administer 0.25 ml (0.5 mg) by mouth three times per day. The medication was documented as administered from 8/22/25 to 8/31/25. The order date was 8/21/25.

It could not be determined nor was it documented regarding how many syringes of morphine sulfate were administered to Tenant #2 at 0.5 ml versus the 0.25 ml ordered; however, Tenant #2 did not receive the medication as ordered. Additionally, no other medication error reports were provided for Tenant #2 or any other tenants in the past three months; however, the picture provided by the Program indicated a bag labeled Tenant #2's lorazepam showed three syringes that did not appear to be drawn up to the correct amount of 0.25 ml as ordered.

3. Record review on 11/06/25 and 11/10/25 revealed Tenant #5's May and June 2025 MARs reflected medications were not administered as

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A 285	Continued From page 11 ordered including: a. On 5/27/25, Donepezil 10 mg tablet, two tablets by mouth every evening was not administered as ordered. The MAR noted "other" but failed to provide a reason medication was not administered. b. On 5/27/25, Simvastatin 40 mg tablet, one tablet by mouth at bedtime was not administered as ordered. The MAR noted "other" but failed to provide a reason medication was not administered. c. On 6/23/25 at 12:00 p.m. and 8:00 p.m., 6/24/25 at 8:00 a.m. and 12:00 p.m., and 6/26/25 at 8:00 p.m. Erythromycin ointment 5 mg/gram, instill ribbon into left eye three times daily until resolved was not administered as ordered. The notes indicated the medication was not available. 4. Record review on 11/10/25 revealed Tenant #6's August to November 2025 MARs reflected medications were not available to administer included: a. At 8:00 p.m., Amlodipine 5 mg tablet, one tablet by mouth twice daily on 8/12/25, 9/02/25, 9/29/25, 9/30/25, 11/05/25 and 11/09/25. Also the morning dose on 11/09/25 and 11/10/25. b. At 8:00 p.m., Atorvastatin 40 mg, one tablet by mouth daily on 8/12/25, 9/02/25, 9/29/25, 9/30/25, and 11/05/25. c. At 8:00 p.m., Donepezil 10 mg tablet, one tablet by mouth at bedtime on 8/12/25 , 9/02/25, 9/29/25, 9/30/25, and 11/05/25. d. At 8:00 p.m., Flutic/Salm aer 250/50, inhale	A 285		

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A 285	Continued From page 12 one puff by mouth twice daily on 8/06/25, 8/08/25, 8/10/25. The 8:00 a.m. dose on 8/08/25 and 8/13/25. Also the 5:00 p.m. dose on 9/22/25, 10/09/25, and 10/10/25. e. At 8:00 p.m., Melatonin 3 mg tablet, one tablet by mouth at bedtime on 8/12/25, 9/02/25, 9/29/25, 9/30/25, 11/05/25 and 11/09/25. f. At 8:00 p.m., Metoprol tartate 50 mg tablet, one tablet by mouth twice daily on 8/12/25, 9/02/25, 9/29/25, 9/30/25 and 11/05/25. When interviewed on 11/10/25 at 10:58 a.m. the Wellness Director confirmed the medications had not been administered as ordered. She reported medication availability and re-ordering of medications had been an issue with the prior pharmacy.	A 285		
A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on observation, interview and record review the Program failed to provide services to tenants in accordance with staff training provided. This pertained to 1 of 1 staff reviewed related to dementia education (Staff A) and 1 of 1 tenant	A 361		

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A 361	Continued From page 13 who eloped (Tenant #1) Findings follow: Record review revealed a Resident Incident Report documented on 7/28/25 at 2:30 a.m. Tenant #1 was found in the common area hallway. The incident report indicated at 2:30 a.m. staff heard an alarm in the distance and observed Tenant #1 in the hallway by the elevators. Staff walked him back to the unit and stayed until another staff arrived. The report noted the tenant sustained no injuries. The report indicated the staff scheduled in the unit left it unattended. Staff A suspended pending the investigation. An interview was unsuccessful with Staff A; however, the Program provided a Staff A's interview completed on 7/28/25 with the Executive Director and Wellness Director. Staff A was asked if she agreed to stay until 3:00 a.m. the day prior and she agreed. She was asked why she clocked out at 2:23 a.m. and reported she had an emergency at home and was tired. She confirmed she had not told anyone or called anyone to let them know she was leaving. She was informed Tenant #1 left the unit while unattended. She confirmed she knew tenants who resided in memory care required a staff in the unit at all times. When interviewed on 11/04/25 at 5:49 p.m. Staff B, assigned to the AL section of the building on the third shift, reported there were four staff in the building the night of the incident. Staff A was the caregiver in the first floor memory care unit. When he completed rounds, he heard an alarm in the distance. He first went to second floor and then to first floor. As he got off the elevator, heard the alarm and saw Tenant #1 dressed in a brief, hat and socks. Staff B immediately ran to him, looked around and saw no other tenants in	A 361		

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A 361	Continued From page 14	A 361		

the hallway. He took Tenant #1 to the first floor memory care unit where he completed a head count in the unit and accounted for everyone. There were a couple of tenants walking in the living room area, which was not unusual.

The caregiver was not in the first floor memory care unit, so he called staff in the second floor unit and the AL. No one knew where the caregiver assigned to the first floor memory care unit was. He called the Wellness Director and reported the staff left. He stayed in the unit until the next staff arrived at 3:00 a.m. (Staff C) and then he went back to the AL section of the building. He said there were no pendant calls or falls in the first floor unit at that time. He reported at the time when the door alarm sounded, the alert did not go to staffs' phones/pager instead it was alarmed at the door. It was not shared with him directly but he heard from another co-worker the next day that Staff A said she could only work until 2:00 a.m. as she was scheduled to be back at work at 7:00 a.m. She had not communicated to him that she would not be able to stay. He thought it was about five to six minutes from when he first heard the alarm to when he found Tenant #1. He mentioned Tenant #1 was up at night 35 to 40 percent of the time.

When interviewed on 11/05/25 at 2:25 p.m. Staff C explained when she came in to work 3:00 a.m. to 3:00 p.m. she became aware of the staff before her left early. When she arrived Tenant #1 was in the unit and the staff informed her Tenant #1 had gotten out of the unit. She spoke with Staff A the next day and she told her she left early. Staff C reported staff were supposed to be in the unit. She was pretty sure she learned of the requirement in training. She noted Tenant #1 attempted to go out of the three doors and he

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A 361	Continued From page 15 was up quite a bit. He liked to be up and active. When interviewed on 11/10/25 at 10:58 a.m. the Wellness Director she was notified Tenant #1 was found outside of the unit by Staff B, walking in the hallway in the fitness area. Staff B walked Tenant #1 back to the unit, checked the apartments, looked for a staff and did not find staff. The Executive Director and Wellness Director met with Staff A and she acknowledged the area was not to be left unattended. The Wellness Director said staff received training on that expectation in the initial training. Staff A did not call the Wellness Director or other staff prior to leaving. At the time of the elopement there would have been at least two other staff there. There were no falls that occurred during the time and no pendants that went unanswered. When interviewed on 11/06/25 at 2:13 p.m. the Executive Director indicated she was notified by the Wellness Director Staff B found Tenant #1 in the AL section of the building, then heard the alarm. He went to the unit with Tenant #1, completed a head count and looked for the staff. Staff B could not find the staff and he or the second-floor memory care staff notified the Wellness Director. The Executive Director confirmed via the cameras Staff A left. She walked to the door with her backpack, propped the door open with the backpack, ran the key back, got her backpack and shut the door. She went and looked into the kitchen, went to the break room, punched out, came back down the hallway and went out the front door. She said about 10 minutes later Tenant #1 went to the door a couple of times and then, pushed on it long enough it opened. He went to the theater, lounge and looked out of the door but did not go outside. He walked down the hall by the fitness desk and	A 361		

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A 361	Continued From page 16	A 361		

Staff B came around the corner. He walked with Tenant #1 back to the unit. Tenant #1 was dressed in shorts and a t-shirt. There was another tenant up in the living room. Tenant #1 did not have any injuries. Staff A agreed to stay until 3:00 a.m. and never called anyone regarding leaving. There were no unanswered pendants or falls she was aware of. When Staff A was interviewed she said "sorry about that" and she kind of had a family emergency and was tired. She acknowledged staff could not leave the tenants unattended and she was aware of the expectation. She was initially suspended and then terminated. The Executive Director indicated there were four staff assigned at that time, including Staff A.

Record review on 11/04/25 and 11/05/25 of Tenant #1's file revealed he was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. His service plan dated 4/10/25 indicated he was to be a one-to-one escort with staff when out of the secured unit. The service plan listed elopement interventions and directed if Tenant #1 displayed signs of elopement to notify the supervisor immediately. The service plan also reflected wandering and interventions related to wandering.

When observed on 11/03/25 at 11:30 a.m. Tenant #1 set off the courtyard door alarm and went to the doors three times during the observation of the medication pass in the memory care unit.

Record review on 11/03/25 on Staff A had a seven credit hour dementia training completed on 3/22/25 and a one hour training related to the Program and dementia care completed on 3/19/25.

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A 361	Continued From page 17 When interviewed on 11/06/25 at 2:13 p.m. the Executive Director indicated Staff A had a one-hour hands on dementia training and in the training staff were provided education to not leave the unit unattended.	A 361		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations within 30 days of tenants taking occupancy. This pertained to 1 of 1 current tenant reviewed admitted in the last six months (Tenant #3). Finding follows: Record review on 11/05/25 of Tenant #3's file revealed an admission date of 3/12/25. A GL Assessment V2 was completed on 3/05/25. An evaluation within 30 days of taking occupancy failed to be completed. When interviewed on 11/10/25 at approximately 12:50 p.m. the Wellness Director confirmed the above finding.	A 140		
A 145	481-69.22(3) Evaluation of Tenant	A 145		

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A 145	Continued From page 18 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 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 4 of 6 current tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Record review on 11/04/25 and 11/05/25 of Tenant #1's file revealed a Resident Incident Report indicated on 7/28/25 at 2:30 a.m. Tenant #1 eloped into the common area hallway. There were no injuries. The incident report indicated at 2:30 a.m. staff heard an alarm in the distance and observed Tenant #1 in the hallway by the elevators. Vital signs were recorded on the incident report. Staff walked him back to the unit and stayed until another staff arrived. The report indicated Tenant #1's family and primary care provider were notified. The report indicated the staff scheduled in the unit left it unattended. That staff had been suspended pending the	A 145		

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A 145	Continued From page 19 investigation. Continued record review revealed Progress notes indicated the following: a. On 7/26/25, Tenant #1 was not sleeping through the night and up the last few nights and was "looking to exit." b. On 7/27/25, Tenant #1 tried to elope. When assisting another tenant with toileting, staff heard the patio door alarm sound and he was seen walking around outside. c. On 7/28/25, Tenant #1 was up all night, not sleeping, pacing and exit seeking. Redirection was successful occasionally. d. On 8/11/25, Tenant #1 woke up at about 4:55 a.m., he was banging on the tables, opening and closing cabinets. e. On 8/13/25, a new order received for melatonin 3 milligram (mg) at bedtime. Further record review revealed evaluations completed on 7/07/25 and 10/03/25. An evaluation failed to be completed with concerns related to his exit seeking and elopement, lack of sleeping and behavior at night, including a new order for melatonin. 2. Record review on 11/05/25 of Tenant #2's file revealed Progress Notes indicated the following: a. On 10/13/25, a new order was received to obtain a urinalysis with culture and sensitivity related to falls and agitation. b. On 10/15/25, a new order was received for	A 145		

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A 145	Continued From page 20 Macrobid 100 milligram (mg), twice daily for five days. Continued record review revealed incident reports indicated Tenant #2 fell or found on the ground nine times between 9/30/25 and 11/02/25. On 11/02/25, she sustained a deep laceration and was sent to the emergency department. Further record review revealed August, September, October and November 2025 MARs reflected at times she refused her medications or spit them out. Observations on 11/03/25 at 11:30 a.m. revealed Tenant #2 refused medications during the medication pass. Continued record review revealed evaluations completed on 3/14/25, 11/03/25 and a 90 day evaluation on 10/04/25. Evaluations failed to be completed when changes occurred including falls, medication refusals, urinary tract infection and treatment. 3. Record review on 11/05/25 revealed Tenant #3's Progress Notes indicated the following: a. On 8/06/25, a new order was received for Lexapro 20 mg by mouth daily. b. On 8/13/25, Tenant #3 did not want to come out for breakfast, she cried and said she did not want to be alive and wanted to be dead. c. On 8/13/25, staff observe for safety issues, attempt to redirect Tenant #3 to participate in one to one activities or other activities in the unit. d. On 8/20/25, Tenant #3 had a tearful couple of	A 145		

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days, would not come out of her apartment, would not visit with others, she was not eating much and would not agree to assistance with changing that morning.

e. On 8/21/25, Tenant #3 cried before breakfast and voiced she felt alone.

f. On 9/03/25, Tenant #3 was seen by a provider due to increased sadness and crying episodes. A new order was received for mirtazapine 15 mg by mouth at bedtime.

g. On 10/22/25, Tenant #3's mood continued to improve. Her episodes of crying and anxiety decreased with decreased visits from her family. She was participating in activities again.

Continued record review of Services Received and Recorded Care Report indicated Tenant #3 routinely refused bathing assistance. The August 2025 and October 2025 MARs reflected at times medications were refused by Tenant #3.

When interviewed on 11/05/25 at 11:43 a.m. the Unit Program Director indicated in the past Tenant #3's apartment frequently had feces in the bathroom that needed to be cleaned up after an accident. She said it occurred pretty frequently as Tenant #3 had more accidents. She indicated Tenant #3 refused bathing 80 percent (%) of the time.

Further record review revealed Tenant #3's evaluations were completed on 3/05/25, 10/02/25 and a 90 day review completed on 7/07/25. Evaluations were not completed for increased tearfulness, a comment about not wanting to live, care refusals, meal refusals, incontinence and management of the bowel incontinence, and new

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A 145	Continued From page 22 medication orders related to the issues. 4. Record review on 11/06/25 of Tenant #4's file revealed Progress Notes indicated the following: a. On 7/26/25, Tenant #4 had a difficult time standing up and getting up with one person and a gait belt. b. On 7/27/25, it was harder for Tenant #4 to stand up. c. On 8/04/25, Tenant #4 was weaker and more difficult to assist. Tenant #4 had a hard time sitting up with the assistance of one person. "It is majority dead weight." d. On 8/23/25, Tenant #2 required the assistance of two staff. She was unable to help stand and it was difficult lifting "dead weight." e. On 8/29/25, Tenant #2 continued to require the assistance of two staff and a care conference was held with Tenant #2's family regarding her exceeding level of care. Continued record review revealed evaluations completed on 3/03/25 and 8/27/25. Evaluations were not completed when Tenant #4's change in mobility and transfers needs occurred. When interviewed on 11/10/25 at 10:58 a.m. the Wellness Director 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:	A 290		

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A 290	Continued From page 23 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 2 of 6 current tenants reviewed (Tenant #4 and Tenant #5) and 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 11/06/25 of Tenant #4's file revealed the November 2025 medication administration record (MAR) reflected an order for cephalexin capsule 500 milligram (mg), one capsule by mouth four times daily for seven days. Cephalexin was ordered on 10/29/25 and discontinued on 10/05/25. Continued record review revealed no documentation in nurse's notes related to the start of the medication, what it was prescribed for or when the medication was discontinued. 2. Record review on 11/06/25 of Tenant #5's file revealed an evaluation completed on 10/06/25 indicated Tenant #5 had three or more falls in the past three months. Continued record review of Tenant #5's file revealed no documentation of nurse's notes provided for September. For October there were the following two entries in nurse's notes:	A 290		

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A 290	Continued From page 24 a. On 10/21/25, it was discussed with family regarding the increase in her falls and discussed the possible benefits of hospice. b. On 10/27/25, it was a follow up to an accident/incident, Tenant #5 was found on the floor in the hallway. She did not have any injuries. Further record review revealed no documented nurses's notes for the increase in falls noted on 10/21/25. 3. Record review on 11/10/25 of Tenant C1's file revealed Tenant C1 was discharged on 5/27/25. Continued record review of her file revealed the only nurse's note in her file from the three months prior to discharge was dated 3/24/25. A discharge note was not completed in the nurse's notes when Tenant C1 was discharged, including the reason and date of her discharge. When interviewed on 11/10/25 at 10:58 a.m. the Wellness Director confirmed all nurse's notes for the tenants reviewed were provided.	A 290		
A 340	481-69.25(2) Tenant Documents 69.25(2) The program records relating to a tenant shall be retained for a minimum of three years after the transfer or death of the tenant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to retain records related to a tenant for three years upon transfer. It pertained to 1 of 2 discharged tenants reviewed (Tenant	A 340		

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A 340	Continued From page 25 C1). Finding follows: Record review on 11/10/25 of Tenant C1's file revealed she was discharged on 5/27/25. Her service plan reflected she received assistance with cares. The Program failed to provide the documentation for the last three months of services prior to discharge for Tenant C1. The Program failed to provide a service summary for Tenant C1. An email received from the Wellness Director on 11/10/25 indicated she was not able to pull Tenant C1's services received for the last three months prior to discharge. Continued record review of Tenant #1, #2, #3, #4, #5 and #6 files revealed documentation indicating the scheduled service, if the task was provided, who provided it, the time and any other notes. The Program provided the service summary included a list of services, visits, hours scheduled and billable hours. When interviewed on 11/10/25 at 10:58 a.m. the Wellness Director confirmed all service logs (tasks) were provided for the tenants reviewed.	A 340		
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.	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0375	A. BUILDING: _____ B. WING _____	C 11/10/2025

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A 350	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete service plans as needed and failed to ensure service plans reflected the service needs of the tenants. This pertained to 6 of 6 current tenants reviewed (Tenants #1, #2, #3 #4, #5 and #6). Findings follow: 1. Record review on 11/04/25 and 11/05/25 of Tenant #1's file revealed a Resident Incident Report indicated on 7/28/25 at 2:30 a.m. Tenant #1 wandered into the common area hallway. The incident report indicated at 2:30 a.m. staff heard an alarm in the distance and observed Tenant #1 in the hallway by the elevators. Staff walked him back to the unit and stayed until another staff arrived. Continued record review revealed Progress notes indicated the following: a. On 7/26/25, Tenant #1 was not sleeping through the night and was up the last few nights and "looking to exit." b. On 7/27/25, Tenant #1 tried to elope. When assisting another tenant with toileting staff heard the patio door alarm go off and was seen walking around outside. c. On 7/28/25, Tenant #1 was up all night, not sleeping, pacing and exit seeking. Redirection was successful occasionally.	A 350		

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A 350	Continued From page 27 d. On 8/11/25, Tenant #1 woke up at about 4:55 a.m. and was banging on the tables and opening and closing cabinets. e. On 8/13/25, a new order was received for melatonin 3 milligram (mg) at bedtime. Further record review revealed Tenant #1's service plan, dated 4/09/25 lacked any updates to the plan to reflect concerns with his exit seeking and elopement at night, lack of sleeping and behavior at night, and a new order for melatonin. 2. Record review on 11/05/25 of Tenant #2's file revealed Progress Notes indicated the following: a. On 10/13/25, a new order was received to obtain a urinalysis with culture and sensitivity related to her falls and agitation. b. On 10/15/25, a new order was received for Macrobid 100 mg, take twice daily for five days. Continued record review revealed incident reports revealed nine times from 9/30/25 to 11/02/25 Tenant #2 fell or found on the ground. On 11/02/25, she sustained a deep laceration and was sent to the emergency department. Further record review revealed the August, September, October and November 2025 MARs reflected at times she refused her medications or spit them out. Observations on 11/03/25 at 11:30 a.m. Tenant #2 refused her medications during the medication pass. Continued record review revealed Tenant #2's service plans, dated 3/14/25 and 11/04/25 failed	A 350		

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A 350	Continued From page 28	A 350		

to be updated as needed when changes occurred including falls, medication refusals, urinary tract infection and treatment.

3. Record review on 11/05/25 of Tenant #3's file revealed Progress Notes indicated the following:

a. On 8/06/25, a new order was received for Lexapro 20 mg by mouth daily.

b. On 8/13/25, Tenant #3 did not want to come out for breakfast. She cried and said she did not want to be alive and wanted to be dead.

c. On 8/13/25, staff observed for safety issues, attempt to redirect Tenant #3 to participate in one to one activities or other activities in the unit.

d. On 8/20/25, Tenant #3 had a tearful couple of days, would not come out of her apartment, would not visit with others, she was not eating much and would not agree to assistance with changing that morning.

e. On 8/21/25, Tenant #3 cried before breakfast and voiced she felt alone.

f. On 9/03/25, Tenant #3 was seen by a provider due to increased sadness and crying episodes. A new order was received for mirtazapine 15 mg by mouth at bedtime.

g. On 10/22/25, Tenant #3's mood continued to improve. Her episodes of crying and anxiety decreased with decreased family visits. She was participating in activities again.

Continued record review of Services Received and Recorded Care Report indicated Tenant #3 routinely refused bathing assistance. The August

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A 350	Continued From page 29 2025 and October 2025 MARs reflected at times medications were refused by Tenant #3. When interviewed on 11/06/25 at 2:13 p.m. the Executive Director indicated regarding visitors, with Tenant #3 there was an agreement with the family and two attorneys. Tenant #3 had a Guardian (non-family member). It was decided one of the family members could come to visit as long as another family member was there too. It was an agreement and everyone was following it. There was not a court order related to the visitation. She indicated one of the family members was upsetting to her, Tenant #3 would isolate in her apartment more after the visit. When interviewed on 11/05/25 at 11:43 a.m. the Unit Program Director indicated in the past Tenant #3's apartment frequently had feces in the bathroom that needed to be cleaned up after an accident. She indicated Tenant #3 refused bathing 80 percent (%) of the time. Further record review revealed Tenant #3's service plans dated 3/12/25 and 10/02/25, failed to reflect Tenant #3's increased tearfulness, a comment about not wanting to be alive, care refusals, meal refusals, incontinence and management of the bowel incontinence, and new medication orders related to the issues. Additionally, the service plan failed to reflect the family and guardian agreement related to visitation. 4. Record review on 11/06/25 revealed Tenant #4's Progress Notes indicated the following: a. On 7/26/25, Tenant #4 had a difficult time standing up and getting up with one person and a gait belt.	A 350		

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A 350	Continued From page 30 b. On 7/27/25, it was harder for Tenant #4 to stand up. c. On 8/04/25, Tenant #4 was weaker and more difficult to assist. Tenant #4 had a hard time sitting up with the assistance of one person. "It is majority dead weight." d. On 8/23/25, Tenant #4 required the assistance of two staff. She was not able to help stand and it was difficult lifting "dead weight." Continued record review revealed service plans were completed on 3/03/25 and 8/27/25. The service plan was not updated as needed and did not reflect the need of the assistance of two staff until 8/27/25; despite changes in Tenant #4's transfers noted in July and prior in August. 5. Record review on 11/06/25 of Tenant #5's file revealed the evaluation completed on 10/06/25 indicated Tenant #5 had three or more falls in the past three months. Continued record review revealed nurse's notes indicated the following: a. On 10/21/25, it was discussed with family regarding the increase in her falls and discussed the possible benefits of hospice. b. On 10/27/25, a follow up to an accident/incident, Tenant #5 was found on the floor in the hallway. She did not have any injuries. Further record review revealed Tenant #5's service plan dated 10/06/25 failed to reflect a history of falls or interventions related to falls.	A 350		

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A 350	Continued From page 31 6. Record review on 11/10/25 of Tenant #6's file revealed Progress Notes indicated the following: a. On 10/20/25, a provider saw Tenant #6 and observed spitting out large amounts of sputum. A new order was received for Mucinex and Prednisone. b. On 10/27/25, Tenant #6 received Mucinex for a week and staff reported improvements related to the sputum. Continued record review revealed Tenant #6's service plan, dated 7/10/25 failed to reflect the issue related to large amount of sputum and ordered treatment. When interviewed on 11/10/25 at 10:58 a.m. the Wellness Director confirmed all service plans were provided for the tenants reviewed.	A 350		
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 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 update the service plan within 30 days of occupancy. This pertained to 1 of 1	A 360		

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A 360	Continued From page 32 current tenant reviewed admitted in the last six months (Tenant #3). Finding follows: Record review on 11/05/25 of Tenant #3's file revealed an admission date of 3/12/25. A service plan was developed on 3/12/25. A service plan failed to be updated within 30 days of taking occupancy. When interviewed on 11/10/25 at approximately 12:50 p.m. the Wellness Director confirmed the above finding.	A 360		
A 410	481-69.26(4)d Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans that reflected planned and spontaneous activities for tenants. This pertained to 5 of 6 current tenants reviewed (Tenants #2, #3, #4, #5 and #6). Findings follow: 1. Record review on 11/05/26 of Tenant #2's file revealed she was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Her service plan dated 11/03/25 indicated she needed reminders and	A 410		

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A 410	Continued From page 33	A 410		

encouragement to attend activities and she would participate in preferred life enrichment activities.

2. Record review on 11/05/25 of Tenant #3's file revealed she was staged at a five on the GDS, which indicated moderately severe cognitive decline. Her service plan dated 10/02/25 indicated she needed reminders and encouragement to attend activities and would participate in preferred life enrichment activities.

3. Record review on 11/06/25 of Tenant #4's file revealed she was staged at a six on the GDS, which indicated severe cognitive decline. Her service plan dated 8/27/25 indicated she needed reminders and encouragement to attend activities and she would participate in preferred life enrichment activities.

4. Record review on 11/06/25 and 11/10/25 of Tenant #5's file revealed she was staged at a six on the GDS, which indicated severe cognitive decline. Her service plan dated 10/06/25 indicated she needed reminders and encouragement to attend activities and she would participate in preferred life enrichment activities.

5. Record review on 11/10/25 of Tenant #6's file revealed he was staged at a five on the GDS, which indicated moderately severe cognitive decline. His service plan dated 7/10/25 indicated he needed reminders and encouragement to attend activities and he would participate in preferred life enrichment activities.

When interviewed on 11/10/25 at 10:58 a.m. the Wellness Director confirmed all service plans were provided for the tenants reviewed.

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A 430	Continued From page 34	A 430		
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: Based on interview and record review the Program failed to complete nurse reviews every 90 days. This pertained to 1 of 2 discharged tenants reviewed (Tenant C1). Finding follows: Record review on 11/10/25 of Tenant C1's file revealed she was discharged on 5/27/25. Tenant C1 received personal and health-related care and a 90 day review was not completed in the three months prior to her discharge. The most recent evaluation completed prior to her discharge was an GL Assessment V2 dated 70/3/24. There failed to be 90 day nurse reviews provided from 7/03/24 to the time of her discharge on 5/27/25. When interviewed on 11/10/25 at 10:58 a.m. the Wellness Director confirmed the above finding.	A 430		

	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
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. 1. Staff will be educated/re-educated on the following policies & procedures: Medication Error Reporting, Resident Accidents-Incidents and Release of Incident Reports. Assistant Wellness Director & Executive Director responsible. 2. Compliance with Resident Accidents-Incidents and Release of Incident Reports will be monitored by the Executive Director & Assistant Wellness Director/Wellness Director by daily weekday review of incident reports.	2/28/2026
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. 1. Memory Care Director has internally transferred, and a new Memory Care Director has been hired with start date scheduled for 2/9/26. The new Memory Care Director is an LPN. Executive Director responsible. 2. Housekeepers were retrained by the Housekeeping Director. Housekeeping Director responsible. 3. A new housekeeping schedule has been created and implemented to ensure all memory care rooms are either deep cleaned (1 day per week) or spot checked (4 days per week) by housekeeping staff. Executive Director, Housekeeping Director, & Lead Housekeeper responsible. Care staff will continue to tidy/restore the bed/area following accidents. Memory Care Director responsible. 4. Retraining on following/documenting care plans will be provided to Wellness staff during staff meetings with attendance sheet sign off or through review/sign off of written material. Assistant Wellness Director, Memory Care Director, and Executive Director responsible. 5. Med Techs are now in charge of the shift and will share staff concerns for correction with Wellness Director, Assistant Wellness Director, Memory Care Director, or Executive Director. Assistant Wellness Director and Executive Director responsible.	2/15/2026
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	2/28/2026

	tenant's physician, advanced registered nurse practitioner or physician assistant. 1. All nurses, medication managers, and CMAs will receive staff education/retraining on Medication Setup-Administration and Storage of Medications policy. Executive Director/designee responsible. 2. The Assistant Wellness Director, Wellness Director, and/or licensed nurse assigned to the community will review the Med error dashboard in Alis at least 2 times per week and complete med error forms as needed.	
A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. 1. Staff responsible for leaving the unit unattended was terminated. Wellness Director and Executive Director responsible. 2. Staffing patterns will be re-evaluated to ensure routine scheduling of at least 2 staff for each memory care neighborhood. Executive Director & Scheduler responsible.	2/28/2026
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall 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. 1. All program nurses have been educated/reeducated on tenant evaluations. Executive Director responsible. 2. A tracking form with checklist for program admissions (including transfers within the community from one licensed program to another) will be developed and initiated to ensure evaluation & service plan completion. Executive Director, Wellness Director, Assistant Wellness Director, and Memory Care Director responsible.	2/28/2026
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 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. 1. All annual and change of condition assessments will be completed by program nurses. New nurses are educated upon hire. Executive Director responsible.	2/28/2026

	2. An assessment tracking form, to include last 2 assessments and type and hospitalizations, will be established to ensure change of condition assessments upon return from hospital. Executive Director and Assistant Wellness Director responsible. 3. The tracking form will be audited at least 2X monthly for 3 months to ensure change of condition and other assessment completion. Wellness Director, Assistant Wellness Director, Memory Care Director, or nurse assigned to the community responsible.	
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. 1. Program nurses will be educated/reeducated on documentation of nurse's notes by exception. Executive Director responsible. 2. Compliance will be monitored by at least monthly audits of 4 randomly selected residents' nurse's notes by the Wellness Director, Assistant Wellness Director, or the licensed nurse assigned to the community.	2/28/2026
A 340	481-69.25(2) Tenant Documents 69.25(2) The program records relating to a tenant shall be retained for a minimum of three years after the transfer or death of the tenant. 1. Record retention requirements have been reviewed with all nurses. Executive Director responsible. 2. Record retention requirements will be added into the on-the-job training of all new nurses. Executive Director and Wellness Director responsible. 3. A checklist that includes tenant record retention for 3 years will be developed for change in software systems relating to tenants so that information remains accessible following the change. Executive Director, Wellness Director, and Assistant Wellness Director responsible.	2/28/2026
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. 1. An assessment/service plan tracking form, to include last 2 assessments & service plans will be established to ensure service plan completion/tracking. Executive Director and Assistant Wellness Director responsible. 2. The tracking form will be audited at least 2X monthly for 3 months to ensure change of condition and other service plan completion. Wellness	2/28/2026

	Director, Assistant Wellness Director, Memory Care Director, or nurse assigned to the community responsible.	
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 and as needed with significant change, but not less than annually. 1. An assessment/service plan tracking form, to include last 2 assessments & service plans will be established to ensure service plan completion/tracking. Executive Director and Assistant Wellness Director responsible. 2. The tracking form will be audited at least 2X monthly for 3 months to ensure change of condition and other service plan completion. Wellness Director, Assistant Wellness Director, Memory Care Director, or nurse assigned to the community responsible.	
A 410	481-69.26(4)d Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests. 1. Service plan form will be reviewed and revised as needed to ensure space to document specific person-centered planned and spontaneous activities for each memory care resident. Memory Care Director and Executive Director responsible. 2. This list will be added as service plans are updated for each resident beginning 2/28/26. Memory Care Director responsible.	2/28/26
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. 1. Program nurses will be educated/re-educated on 90-day nurse review requirements. Executive Director and Wellness Director responsible. 2. Monthly audits of 4 randomly selected service plans and nurse reviews will be completed for the next 3 months to ensure compliance. Wellness Director, Assistant Wellness Director, or Licensed nurse assigned to the community responsible.	2/28/2026