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
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317 See attached POC 5/29/26

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 48 Tenants with cognitive impairment: 1 Total census: 49 The following regulatory insufficiencies were identified related to the investigation of Complaint #130875-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program:	A 000	A 116: 1. All care staff will be re-educated on incident reporting policy by 5/29/26. 2. Yearly re-education on incident reporting will be completed with all care staff. 3. Quarterly audits to be completed by DHW on incident reports to ensure compliance with our policy. 4. Regulatory insufficiency will be corrected by 5/29/26	
A 116	481-67.2(2) Program Policies and Procedures 67.2(2) 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 the completion of incident reports. This pertained to 1 of 4 current tenants reviewed (Tenant #2) and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow: 1. Record review on 4/13/26 and 4/14/26 of Tenant #2's file revealed Observations (nurse's notes) revealed on 3/17/26 it noted, a staff to nurse communication form, dated 3/16/26, indicated at 11:45 a.m. staff went into the apartment to check on Tenant #2. She was brushing her teeth. At about 12:30 p.m., staff returned with Tenant #2's meal and noticed the carpet in the bedroom was wet. Staff went to the bathroom and the shower was on, the	A 116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 116	Continued From page 1	A 116		

showerhead was down, swinging water all over. Staff told Tenant #2 she left the shower on and she appeared to have forgotten. Staff notified a leadership staff that water was dripping into two other apartment bathrooms. Maintenance was also notified.

Continued record review revealed an incident report was not completed related to the 3/16/26 incident with Tenant #2.

2. Record review on 4/14/26 to 4/16/16 of Tenant C2's file revealed Observations (nurse's notes) indicated on 11/17/25 it noted Tenant C2 had a major stroke on 11/14/25. He was inpatient (palliative) at the hospital. The goal was for him to return to the Program on hospice and comfort cares only. He was not currently eating, drinking and was bed-bound.

Continued record review revealed a Client Coordination Note Report indicated on 11/14/25 he was brought to the hospital after he was found in his apartment, did not have the ability to speak and was not moving the right side of his body.

Further record review revealed an incident report was not completed related to the 11/14/25 incident with Tenant C2.

Record review on 4/16/26 revealed the Program's policy incident reporting, dated 9/6/17, indicated all accidents or unusual occurrences that affected a tenant should be reported as incidents. An Incident Report Form would be completed for all falls, injuries, medication errors, accidents, anything unusual and allegations of abuse.

When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness confirmed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 116	Continued From page 2 above finding.	A 116	A 152: 1. Previous Director of Health and Wellness has been terminated.	
A 152	481-67.5(2)e(3) Medications 481-67.5(231B,231C,231D) Medications. 67.5(2)?Each program shall follow its own written medication policy, including the following: e. When medications are administered traditionally by the program: (3) Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or PA. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer medications timely as ordered including comfort medications. This pertained to 1 of 2 discharged tenants reviewed (Tenant C1). Finding follows: Record review on 4/14/26 to 4/16/26 of Tenant C1's file revealed Tenant C1 received staff assistance with medication administration and was on hospice. Tenant C1 died on 10/9/25. Tenant C1's file revealed medications were not administered timely as ordered included: 1. A Medication Profile indicated an order for Olanzapine five milligram (mg) tablet, one tablet every four hours as needed for anxiety/agitation. It was discontinued on 8/30/25. The August and September 2025 medication	A 152	2. Nursing current practice is to update MAR's and notify pharmacy as soon as possible after order is received. 3. DHW to perform quarterly audits to ensure timely initiation of orders. 4. Regulatory insufficiency will be corrected by 5/29/26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 3	A 152		

administration records (MARs) reflected Olanzapine five mg tablet, one tablet every four hours as needed. It was started on the MAR on 8/27/25 and remained on the MAR for the remainder of the month of August and was not discontinued until 9/2/25.

2. A Patient Care Order reflected an order for morphine 20 mg/milliliter (ml), two mg (2 mg = 0.1 ml) every four hours as needed for pain or dyspnea. Discontinue morphine 20 mg/ml, administer five mg (5 mg=0.25 ml) every four hours as needed for pain, shortness of breath. The order was dated 9/25/25 at 11:18 a.m. It was noted on 10/3/25 by the Former Director of Health and Wellness.

The September 2025 MAR reflected morphine sulfate, 0.25 ml every four hours as needed for pain. It was given on 9/28/25 and 9/30/25; despite being discontinued on 9/25/25. The MAR did not reflect it was discontinued. The September MAR also did not reflect the new order for morphine administer 2 mg (0.1 ml) every four hours as needed.

3. A Patient Care Order reflected orders including for lorazepam 2 mg/ml (0.5 mg=0.25 ml), oral concentrate, 0.5 mg, every four hours as needed for restlessness, anxiety, and agitation. Lorazepam 0.5 mg tablet, administer one tablet every four hours as needed for anxiety was discontinued. The order was dated 10/1/25 at 3:07 p.m. An order was received to discontinue the lorazepam 2 mg/ml, 5 mg every four hours as needed on 10/1/25 at 3:25 p.m.

The October 2025 MAR reflected the order for lorazepam, one tablet every four hours as needed for anxiety was not discontinued from the MAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 4 until 10/3/25. 4. A Patient Care Order reflected an order for morphine 20 mg/ml oral concentrate, two mg every six hours. The order was dated 10/1/25 at 10:06 a.m. It was noted on 10/2/25 by the Former Director of Health and Wellness. The October 2025 MARs reflected the order for morphine was not started on the MAR until 10/2/25. 5. A Patient Care Order reflected orders including for haloperidol two mg/ml, 0.25 ml, every four hours for anxiety and restlessness. Morphine sulfate 20 mg/ml 0.1 ml, every four hours for pain, discomfort and morphine 20 mg/ml, 0.1 ml every two hours as needed. Additionally, morphine 20 mg/ml, 2 mg (0.1 ml) every four hours as needed and morphine 20 mg/ml, two mg (0.1 ml) every six hours were discontinued. The order was dated 10/2/25 at 1:42 p.m. A Patient Care Order reflected handwritten times for two medications, haloperidol and morphine sulfate. Haloperidol 12:00 a.m., 4:00 a.m., 8:00 a.m. 12:00 p.m., 4:00 p.m. and 8:00 p.m. Morphine Sulfate at 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m. and 10 p.m. It was noted by the Former Director of Health and Wellness on 10/2/25. The October 2025 MAR reflected the orders for the scheduled haloperidol 0.25 ml every four hours and morphine 0.1 ml every four hours were not reflected as administered on the MAR until 10/3/25. 6. A Patient Care Order reflected an order including for haloperidol 2 mg/ml, 0.25 ml, every six hours for anxiety and restlessness and morphine 20 mg/ml, 0.1 ml, every two hours for	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 5	A 152		

pain, shortness of breath and discomfort. Haloperidol 0.25 ml, every four hours and morphine 20 mg/ml, 0.1 ml, every four hours were discontinued. The order was dated 10/6/25 at 11:26 a.m.

The October 2025 MAR reflected the new order for the haloperidol 0.25 ml, every six hours was not reflected on the MAR until 10/7/25. Additionally, the times of the medication were adjusted and moved an hour later on 10/9/25 from the times reflected on 10/7/25. The October MAR reflected the new order for the morphine 0.1 ml, every two hours, however, it also was not reflected on the MAR until 10/7/25. Additionally, the times of the medication were adjusted and moved an hour later on 10/9/25 from the times reflected on 10/7/25.

7. A Patient Care Order reflected a new order for morphine 20 mg/ml, 2 ml every two hours for pain. It was ordered on 10/9/25 at 10:10 a.m.

The October 2025 MAR reflected the order for the morphine 20 mg/ml, 2 ml every two hours for pain; however, it was not reflected on the MAR until 10/10/25 (after Tenant C1's death). No doses were documented as administered.

When interviewed on 4/16/26 at 11:16 a.m. the Director of Health and Wellness said she could not speak to the situation. She said leadership staff knew it was a problem with the Former Director of Health and Wellness.

When interviewed on 4/16/26 at 12:29 p.m. the Executive Director reported the Former Director of Health and Wellness was hired on 8/26/25 and she was terminated related to performance issues on 11/12/25. He indicated there had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 6 delays on faxes more related to Tenant C1. It was related to timeliness, accuracy of faxes, correct dose and frequency. The Executive Director also provided a written timeline of re-education for the Former Director of Health and Wellness. On 9/12/25 she was re-educated about noting faxes and responding to faxes, on 10/2/25 re-education was completed by phone regarding order changes for Tenant C1 that had not been updated. Tenant C1's family called the Executive Director on 10/2/25 and said the orders had not been updated and medication managers could not administer the medications. The Executive Director called the Former Director of Health and Wellness and requested she get the order updated so staff could administer the medication. On 10/6/25 it was noted the Executive Director met with her again about Tenant C1's orders regarding being updated and accurate. She started verifying orders with hospice at that point due to family concerns the orders were not being addressed timely and accurately. She had additional counseling on 11/3/25, 11/5/25 and she was re-educated and monitored on 11/6/25 and 11/10/25 and she was terminated on 11/12/25 due to lack of improvement related responsiveness to accuracy of faxes and medication changes.	A 152		
A 232	481-69.22(3) Evaluation of Tenant 481-69.22(231C) 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	A 232	A 232: 1. Nursing to be re-educated on AL regulations in regards to requirements of a significant change. 2. Nursing team will take AL regulations course when available to re-educate on regulations. 3. Regulatory insufficiency will be corrected by 5/29/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 232	Continued From page 7	A 232		

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.

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 2 discharged tenants reviewed (Tenant C1). Finding follows:

Record review on 4/14/26 to 4/16/26 of Tenant C1's file revealed Observations (nurse's notes) indicated the following:

-On 9/26/25, Tenant C1 had low urine output and complaints of low back pain.

-On 9/30/25, Tenant C1 was unable to swallow pills or drink fluids. The hospice nurse was contacted regarding not being able to swallow per staff reports. Hospice was to make all medications liquid if possible.

-On 10/1/25, a message was left for hospice to check on orders for liquid medications due to the tenant not swallowing well.

-On 10/1/25, new orders were received for liquid medications.

-On 10/14/25, Tenant C1 was deceased (10/9/25).

Continued record review revealed evaluations were most recently completed on 8/27/25. Evaluations were not completed as needed with significant change when Tenant C1 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 232	Continued From page 8 swallowing issues, low urine output, and liquid medications were initiated. When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness confirmed the above finding.	A 232		
A 235	481-69.23(1)a Criteria for Admission and Retention 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: a. Is bed-bound; or This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to discharge a tenant or apply for waiver timely related to a tenant who exceeded the level of care. This pertained to 1 of 2 discharged tenants reviewed (Tenant C2). Finding follows: Record review on 4/14/26 to 4/16/16 of Tenant C2's file revealed a Client Coordination Note Report indicated on 11/14/25 he was brought to the hospital after he was found in his apartment and did not have the ability to speak and was not moving the right side of his body. Continued record review revealed Observations (nurse's notes) indicated the following: -On 11/17/25, Tenant C2 had a major stroke on	A 235	A 235: 1. Nursing re-educated on regulations in regards to admission and retention. 2. Nursing to request waiver for any residents exceeding AL LOC. 3. Nursing to take AL regulations course to refresh on current regulations. 3. Regulatory insufficiency will be corrected by 5/29/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 235	Continued From page 9	A 235		

11/14/25. He was inpatient (palliative) at the hospital. The goal was for him to return to the Program on hospice and comfort cares only. He was not currently eating, drinking and was bed-bound.

-On 11/19/25, a change of condition was completed for admission back to the Program.

-On 12/1/25, the hospice nurse notified the Director of Health and Wellness that Tenant C2 improved slightly post stroke. Hospice was going to discuss long term care options with Tenant C2's family due to him requiring more assistance than the Program was able to provide.

-On 12/8/25, the hospice nurse lowered Tenant C2's bed as low as possible as he attempted to get up on his own. A message was left by the hospice social worker for Tenant C2's family to discuss a higher level of care as he had been stable.

-On 12/9/25, a discussion was held with Tenant C2 and his family. Tenant C2 did not want to transfer out of bed and he did not want more food than was being offered when family was there. Tenant C2 was at a new baseline and needed extra support due to the family not sitting at his bedside for the majority of the day.

-On 12/9/25, Tenant C2 was transferred to another hospice provider. A hospice waiver was faxed to the Department.

-On 12/15/25, Tenant C2 was actively dying. He was non-responsive with 10 to 15 seconds of apnea.

-On 12/15/25, Tenant C2 passed away.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 235	Continued From page 10 Further record review revealed the Request for Waiver of Administrative Rule was completed on 12/9/25. It was completed for rule cite 69.23 (1) (a). The document noted it was faxed on 12/9/25. Continued record review revealed a Waiver of Administrative Rule was not completed prior to 12/9/25 and he exceeded level of care from his return on 11/19/25 post stroke and was bed bound. When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness indicated he was bed bound and was not a two person transfer.	A 235		
A 280	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with rule 481-69.22(231C) and be designed to meet the specific needs of the individual tenant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans that reflected the service needs of the tenants. This pertained to 4 of 4 current tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Record review on 414/26 of Tenant #1 file revealed Observations (nurse's notes) indicated the following:	A 280	A 280: 1. Tenant charts updated to reflect specific care needs 2. Staff re-educated on following care plan and notifying nursing if discrepancies are noted by filling out a staff to nurse communication form. 3. Nursing re-educated on updating service plans to meet the specific needs of the tenants and monitoring MAR's and TAR's with all reviews. 4. Regulatory insufficiency will be corrected by 5/29/2026	

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
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 280	Continued From page 11 -On 1/16/26, Tenant #1 was incontinent of bowel in her chair and bathroom. Tenant #1 reported to staff she had cleaned up; however, there was bowel movement (BM) noted on her legs and perineal area. Tenant #1 agreed to take a shower. -On 2/3/26, a staff to nurse communication dated 1/30/26 indicated Tenant #1 used per pendant and staff noticed BM on the bathroom floor by the toilet with toilet paper over it. -On 2/12/26, a staff to nurse communication indicated Tenant #1 had a large BM in front of the toilet. -On 2/23/26, a staff to nurse communication dated 2/22/26 indicated after Tenant #1's shower, she lost her balance twice and staff stabilized her to prevent her from falling. Tenant #1 was struggling to move her right foot and dragging it. Tenant #1 said her right foot did not want to move. It was possible Tenant #1's Parkinson's disease was worsening. -On 3/3/26, a staff to nurse communication indicated Tenant #1 was seated on the toilet and staring at BM on the floor. Staff asked what happened and Tenant #1 said she missed. Staff reported it happened frequently but it was the first report to nursing. -On 3/6/26, kitchen staff reported to staff that she was choking. Tenant #1 was able to cough up a piece of bacon. Continued record review of incident reports indicated Tenant #1 fell on 1/29/26, 1/30/26, 3/8/26.	A 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 280	Continued From page 12 Further record review revealed Tenant #1 ' s service plan dated 4/11/26 reflected Tenant #1 had a risk of falling and to notify nursing if more unstable, to file an incident report if a fall occurred. The service plan indicated Tenant #1 had intermittent episodes of bowel incontinence but managed independently. The service plan did not reflect the frequency of the bowel incontinence and staff assistance, Tenant #1's right foot dragging, and interventions related to falls. When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness indicated for Tenant #1 the service plan reflected bowel incontinence; she was independent and staff assisted as needed. The foot drop was not on the service plan. The service plan reflected a shower mat in the shower (related to falls). 2. Record review on 4/13/26 of Tenant #2's file revealed Observations (nurse's notes) indicated the following: -On 3/2/26, staff reported when coming onto the shift at 6:00 a.m. staff completed safety checks and Tenant #2 was in the hallway without shoes or her oxygen. Later she was observed in her apartment wearing one shoe and no oxygen. At noon she was in the hallway without oxygen and was looking for cake mixes. Before shift change, she pushed her pendant and fell. Tenant #2 and her family reported she was hallucinating. -On 3/17/26, a staff to nurse communication form dated 3/16/26, indicated at 11:45 a.m. staff went into the apartment to check on Tenant #2. She was brushing her teeth. At about 12:30 p.m. staff returned with Tenant #2's meal and noticed the	A 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 280	Continued From page 13	A 280		

carpet in the bedroom was wet. Staff went to the bathroom and the shower was on, the showerhead was down, swinging water all over. Staff told Tenant #2 she left the shower on and she appeared to have forgotten. Staff notified a leadership staff that water was dripping into two other apartment bathrooms. Maintenance was also notified.

Continued record review revealed the January to April task administration records (TARs) reflected care refusals for toileting, dressing, hearing aide assistance and escorts to meals.

Further record review Tenant #2 ' s service plan dated 4/10/26 reflected Tenant #2 received assistance with dressing, escorts to meals, toileting and hearing aides. The service plan did not reflect Tenant #2's care refusals as noted above and interventions.

When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness confirmed the hallucinations, behavior were not on the service plan for Tenant #2.

3, Record review on 4/14/26 of Tenant #3's file revealed Observations (nurse's notes) indicated the following:

-On 3/19/26, an addendum to the change of condition from 3/17/26, including the medication manager was to weigh him daily.

-On 3/20/26, a staff to nurse communication dated 3/19/26 indicated Tenant #3 appeared very confused regarding what he should be doing. At times Tenant #3 was short of breath, especially with exertion. Tenant #3 was anxious and unsure of his routine as he was hospitalized twice and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 280	Continued From page 14 was out at a rehabilitation facility. -On 3/24/26, therapy staff contacted the nurse to report Tenant #3's oxygen saturation was 80% on room air. Tenant #3 had a six-pound weight gain in two days. His arms and legs were edematous. -On 3/25/26, Tenant #3 was re-admitted to the hospital. -On 4/1/26, Tenant #3 returned to the Program. -On 4/6/26, Tenant #3 had a three-pound weight gain and his oxygen saturation was in the 80's. -On 4/10/26, Tenant #3 was admitted to the hospital and could not have his scheduled angiogram due to fluid overload. Tenant #3 was admitted and would be diuresed. Continued record review revealed Tenant #3's service plan dated 4/1/26 reflected history of heart failure and to report new or increased swelling, shortness of breath or fatigue to nursing. The service plan did not reflect the daily weights and fluid overload. When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness confirmed the service plan for Tenant #3 did not include weights, she indicated it was not ordered and was a nursing judgement. 4. Record review on 4/14/26 of Tenant #4's file revealed Observations (nurse's notes) indicated on 3/11/26 an air mattress topper was delivered and put on Tenant #4's bed to prevent pressure sores. Continued record review revealed Tenant #4 ' s	A 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 280	Continued From page 15 service plan, dated 1/5/26 was not updated to reflect the air mattress topper in place to prevent pressure sores. When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness confirmed the mattress was not on the service plan for Tenant #4.	A 280		
A 282	481-69.26(3) Service Plans 481-69.26(231C) 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. The service plan shall be signed by all parties, including the tenant or tenant's legal representative. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update the service plans as needed with a significant change. This pertained to 1 of 2 discharged tenants reviewed (Tenant C1). Finding follows: Record review on 4/14/26 to 4/16/26 of Tenant C1's file revealed Observations (nurse's notes) indicated the following: -On 8/6/25, Tenant C1 required the assistance of two staff from the wheelchair to recliner. -On 8/7/25, Tenant C1 required the assistance of two staff to transfer.	A 282	A 282: 1. Nurse re-educated on timeliness of evaluations. 2. Nursing team to attend AL regulations course to re-educate on regulations. 3. Keystone to implement weekly nursing meetings to discuss residents with changes in care needs to ensure proper evaluations are being completed. 4. Regulatory insufficiency will be corrected by 5/29/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 282	Continued From page 16 -On 8/8/25, a change of condition was completed to add bathing, as needed transfers/ambulation, dressing twice daily and meal delivery. -On 8/18/25, staff reported Tenant C1 required the assistance of two staff that morning. -On 8/22/25, Tenant C1 required the assistance of at least two staff for all transfers and was ambulating minimally. -On 8/27/25, a change of condition was completed. She required the assistance of three staff for transfers and was now staying in bed full time. -On 9/15/25, an approval was received for a waiver from the Department. -On 9/26/25, Tenant C1 had low urine output and complaints of low back pain. -On 9/30/25, Tenant C1 was unable to swallow pills or drink fluids. The hospice nurse was contacted regarding not being able to swallow per staff reports. Hospice was to make all medications liquid if possible. -On 10/1/25, a message was left for hospice to check on orders for liquid medications due to the tenant not swallowing well. -On 10/1/25, new orders were received for liquid medications. -On 10/14/25, Tenant C1 was deceased (10/9/25). Continued record review revealed Tenant C1 ' s	A 282		

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
	S0393	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN AL	1275 WEST FOREVERGREEN NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 282	Continued From page 17 service plans were completed on 8/8/25, 8/13/25, 8/14/25 and 8/27/25. The service plans of 8/8/25, 8/13/25 and 8/14/25 did not reflect at times Tenant C1 required the assistance of two or three staff for transfers. Additionally, the service plan was not updated with significant change when Tenant C1 had swallowing issues, low urine output, and liquid medications were initiated. When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness confirmed the above finding.	A 282		