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
	S0400	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT INDIAN CREEK	325 COLLINS ROAD SE CEDAR RAPIDS, IA 52403

(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: 131 Tenants with cognitive impairment: 2 Total census: 133 The following regulatory insufficiencies were cited related to the investigation of complaints #127819-C and #128010-C:	A 000		
A 220	481-69.24(1)b Involuntary Transfer from Program 69.24(1) Program initiation of transfer. If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply: b. The program shall immediately provide to the office of long-term care ombudsman, by certified mail, a copy of the notification and notify the tenant's treating physician, if any. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to immediately provide notification of involuntary transfer to the long-term care ombudsman. This pertained to 1 of 1 tenant reviewed that received a 30-day notice to transfer (Tenant C1). Finding follows:	A 220		

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A 220	Continued From page 1 1. Record review on 8/26/25 of Tenant C1's file revealed Tenant C1 received a 30-day notice dated 1/29/25. The notice indicated various dates of discussion with Tenant C1 about smoking inside the apartment. On 1/28/25, the letter noted when the Executive Director entered her apartment she was holding a lit cigarette and a pack of cigarettes. The letter indicated Tenant C1 confirmed she bought the cigarettes earlier in the day and she preferred to smoke them in the evening in her apartment. The notice indicated she signed an occupancy agreement on 5/15/23 that indicated the Program did not allow smoking. The letter failed to indicate the Long-Term Care (LTC) ombudsman or documentation of notification to the LTC ombudsman. Another 30-day notice letter was issued dated 3/28/25. The notice indicated since the prior letter was received on 1/29/25, Tenant C1 continued to smoke in the apartment. Various dates were provided where staff smelled smoke in and near her apartment. On 3/26/25 staff found cigarettes in the garbage in her apartment. When the bag was opened there were multiple cigarettes inside. The notice noted despite interventions to help her stop smoking, she continued to smoke in her apartment. It indicated she signed an occupancy agreement on 5/15/23 that indicated the Program did not allow smoking. The notice provided the name and contact number for the LTC Ombudsman. There was no documentation provided related to the notification of the LTC Ombudsman when the transfer notice was given. Further record review revealed an investigation indicated Tenant C1 tested positive for illegal substances while hospitalized. The investigation document indicated items were found in the apartment and police were notified. Tenant C1's	A 220		

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A 220	Continued From page 2 Power of Attorney (POA) granted police permission to enter the apartment and remove the "contraband." Prior, Tenant C1 had been hospitalized for being a safety concern to herself and others. She smoked in her apartment and put the cigarettes out in a plastic bag. She had been issued a 30-day notice prior to being hospitalized related to safety and non-compliance related to smoking. The document indicated the Executive Director spoke with the LTC Ombudsman regarding the incident with Tenant C1 and the 30-day notice from 4/04/25 to 4/07/25. Continued record review revealed a timeline of dates provided by the Director of Health and Wellness, she indicated Tenant C1 went to the hospital on 4/01/25 and returned on 4/01/25. She went to the hospital on 4/03/25 and returned on 4/07/25. Tenant C1 was committed on 4/11/25 and did not return. A list of discharged tenants indicated Tenant C1 moved out on 5/01/25 due to non-compliance with smoking. When interviewed on 8/27/25 at 3:43 p.m. the Executive Director confirmed the LTC Ombudsman was contacted by phone a week after the transfer notice was given. She spoke with the LTC Ombudsman from 4/04/25 to 4/07/25 regarding the incident with Tenant C1 and the 30-day notice. She also confirmed Tenant C1's transfer was an involuntary transfer.	A 220		
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 3 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 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Record review on 8/26/25 revealed Tenant C1's Progress Notes indicated the following: a. On 4/2/25, Tenant C1 went to the emergency department (ED) yesterday after "threatening suicide" and she attempted to hit staff. She returned back to the Program that night with nicotine patches. The document also noted there was an attempt to establish care with a primary care provider (PCP). b. On 4/03/25, an incident report was noted. c. On 4/07/25, Tenant C1 returned from the hospital with a 24 hours/ 7 days a week/7 (24/7) private duty caregiver related to concerns with making safe choices. d. On 4/11/25, the PCP contacted would not establish care for Tenant C1 since she was moving out soon. Continued record review revealed the following:	A 290		

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A 290	Continued From page 4	A 290		

a. An evaluation dated 4/07/25 indicated Tenant C1 received a 30-day notice to transfer due to continued tobacco use in her apartment. On Thursday she threatened to kill herself and was taken to the ED for a psych evaluation. A drug test was also completed and she tested positive for illegal substances. Tenant C1 was able to return to her apartment with a 24/7 private duty caregiver. Due to the drug testing the transfer process was expedited.

b. A timeline of dates provided by the Director of Health and Wellness indicated Tenant C1 went to the hospital on 4/01/25 and returned on 4/01/25. She went to the hospital on 4/03/25 and returned on 4/07/25. She was committed on 4/11/25 and did not return.

c. A list of discharged tenants revealed Tenant C1's moved out on 5/01/25 due to non-compliance with smoking.

Further record review revealed Tenant C1 received a 30-day notice, dated 1/29/25, indicated discussion with Tenant C1 on various dates about smoking inside the apartment. On 1/28/25 it was noted when the Executive Director entered her apartment she was holding a lit cigarette and a pack of cigarettes. The letter indicated Tenant C1 confirmed she had bought them earlier in the day and she preferred to smoke them in the evening in her apartment. She was issued a second 30-day notice to transfer dated 3/28/25.

Continued record review revealed nurse's notes were not documented by exception for Tenant C1 including what occurred with the first 30-day notice dated 1/29/25. Nurse's notes were also not documented by exception when she went to the hospital on 4/03/25 and 4/11/25 and when she

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A 290	Continued From page 5 was discharged from the Program. 2. Record review on 8/27/25 revealed Tenant C2's Progress Notes indicated the following: a. On 3/6/25, Tenant C2 was found in another tenant's apartment and was brought back to his floor and apartment. Staff responded and he was weak and unstable. Tenant C2 was not able to speak and could only mumble. Tenant C2's family was notified and declined to have him sent out by emergency medical services (EMS) and family would arrive shortly. It was reported Tenant C2 became physically abusive toward the family. It was noted his face seemed asymmetrical by the nurse in a video call. Due to his behaviors, change in cognition,decreased coordination and possible stroke symptoms, his family was advised EMS needed to be called and the family agreed. It was reported Tenant C2 attempted to grab a knife to harm the family. b. On 3/6/25, a meeting was held with staff and Tenant C2's family (by phone). The staff explained to Tenant C2's family, due to his cognitive status, safety of him and others, he could not live in the assisted living section of the building alone. Two options were provided to move him to memory care or for the family to provide and set up a 24/7 caregiver. The family agreed to work on transferring him to memory care in the morning. It was noted the staff in the ED was asked if they could keep him overnight for observation as they were not able to accommodate him currently in his assisted living apartment. c. On 3/7/25, a call was received from the hospital and they needed to discharge the tenant today. A call with family indicated the family	A 290		

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A 290	Continued From page 6 thought he was staying at the hospital through the weekend. Family was again told he was not safe in the Program unless he was in memory care or had a 24/7 caregiver. The family indicated there was a meeting with someone later today and the family member would call back with the plan. d. On 3/18/25,a one-time credit was approved on the account. Continued record review revealed Tenant C2's date of discharge was 4/07/25. It indicated there was no agreement with the level of care recommendations and he moved out. Further record review revealed nurse's notes were not documented by exception regarding Tenant C2's discharge and reason for discharge from the Program. When interviewed on 8/27/25 at 2:20 p.m. the Director of Health and Wellness confirmed all nurse's notes were provided for the tenants reviewed.	A 290		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.	A 350		

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A 350	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed and failed to ensure service plans reflected the service needs of a tenant. This pertained to 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Record review on 8/26/25 of Tenant C1's file revealed Tenant C1 received a 30-day notice dated 1/29/25, indicated discussion with Tenant C1 on various dates about smoking inside the apartment. On 1/28/25 when the Executive Director entered her apartment she held a lit cigarette and a pack of cigarettes. The letter indicated Tenant C1 confirmed she bought them earlier in the day and she preferred to smoke them in the evening in her apartment. The notice indicated she signed an occupancy agreement on 5/15/23 that indicated the Program did not allow smoking. Another 30-day notice letter was issued dated 3/28/25, noted since the prior letter was received on 1/29/25, Tenant C1 continued to smoke in the apartment. The notice indicated various dates where staff smelled smoke in and near her apartment. On 3/26/25, staff found cigarettes in the garbage in her apartment. When the bag was opened there were multiple cigarettes inside. The letter noted despite interventions to help her stop smoking, she continued to smoke in her apartment. The letter indicated she signed an occupancy agreement on 5/15/23 that indicated the Program did not allow smoking. Continued record review revealed incident reports indicated the following:	A 350		

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A 350	Continued From page 8 a. On 4/1/25 Tenant C1 voiced a suicidal ideation. She was upset, isolated herself in the apartment due to being re-educated on the Program's no smoking policy and procedure. It was determined Tenant C1 needed a psychiatric evaluation and her power of attorneys (POAs) agreed. The report noted the emergency department (ED) provided Tenant C1 with nicotine patches. b. On 4/3/25 staff entered her apartment and smelled smoke. There were hot ashes and had burned through a bag in the garbage. Tenant C1's POAs were notified and they called the police. Police advised them to commit her to the hospital and to get a letter from the judge. Emergency medical services (EMS) transported Tenant C1 to the hospital. The report noted while admitted to the hospital over the weekend, the POAs told the Executive Director Tenant C1 tested positive for illegal substances. A substance was found in a bag in the apartment and turned over to police. The Program allowed Tenant C1 to return but required she had a 24/7 private duty caregiver. The report noted there were no visitors allowed unless approved by the Executive Director and family. Further record review revealed Tenant C1's service plan dated 3/06/25 failed to reflect Tenant C1's history of non-compliance with the Program's smoking policy and interventions related to smoking cessation. The service plan was updated on 4/07/25; however, the service plan failed to reflect the history of non-compliance with the Program's smoking policy, interventions related to smoking cessation, history of a suicidal ideation, the 24/7 private duty caregiver and the restriction of visitors.	A 350		

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A 350	Continued From page 9 2. Record review on 8/27/25 revealed Tenant C2's Progress Notes indicated the following: a. On 2/19/25, Tenant C2 at times continued to have non-threatening hallucinations. b. On 2/19/25, Tenant C2 had a non-threatening hallucination. The primary care provider (PCP) was made aware and no new orders were received. c. On 2/26/25, Tenant C2 came to the lobby and seemed more confused. Continued record review revealed Tenant C2's service plan dated 2/26/25 indicated Tenant C2 had moderate confusion. The service plan failed to reflect the history of hallucinations and any interventions related to the hallucinations. When interviewed on 8/27/25 at 2:20 p.m. the Director of Health and Wellness confirmed all service plans were provided for the tenants reviewed.	A 350		