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
	S0401	A. BUILDING: _____ B. WING _____	C 02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING AT INDIAN CREEK MC	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 for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 1 Number of tenants with cognitive impairment: 29 Total census: 30 The following regulatory insufficiencies were cited during the investigations of Complaint #123049-C, #125889-C, #126386-C, Incident #126382-I and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000		
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 policies regarding falls with injuries and securing narcotics. Findings follow: 1. On 1/14/25 at approximately 9:00 a.m. observations revealed Tenant #4's bottle of Morphine in an unlocked mini refrigerator in the locked medication room. No locking mechanism was observed on the refrigerator. During observations with the Director of Health	A 150	The locking mechanism of the refrigerator that stored Tenant #4's morphine was repaired on 2/14/2025. Tenant #C-1 no longer resides in the community. On 3/12/2025, the Director of Maintenance inspected all refrigerators containing narcotics to ensure that the locking mechanisms were operational. The Director of Health and Wellness (DOHW) conducted staff training on 1/31/2025 and 3/12/2025 regarding the narcotic policy and the policy regarding Falls with possible head injuries. The Director of Health and Wellness (DOHW) or Designee will perform random weekly refrigerator audits for three months to ensure compliance with our policy. Additionally, the Director of Health and Wellness (DOHW) or a designee will perform random audits weekly for the next three months to ensure that the nurse is called immediately when a fall results in a head injury.	4/4/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: JOAN RANDALL — TITLE: EXCUTIVE DIRECTOR — (X6) DATE: 03/14/25

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A 150	Continued From page 1 and Wellness (DHW) and Assistant Director of Health and Wellness (ADHW) at 9:15 a.m., they confirmed the refrigerator containing the Morphine was not locked. The ADHW said there was a locking mechanism on the refrigerator at some point previously, but it broke. When interviewed at 9:25 a.m. on 1/14/25 the Maintenance Director said staff told him of the broken lock about two weeks prior and he ordered a part. He said the part came in, but he hadn't fixed the lock yet. He indicated he didn't know if the nursing staff was aware the refrigerator was unlocked during this time. The refrigerator with Morphine continued to be unlocked when checked at 2:20 p.m. at 1/14/25. Staff A said she had worked in the Memory Care unit for about one month and did not recall the refrigerator being locked during that time. Program policy entitled, "Controlled Medications" indicated, "All narcotics will be stored ONLY in double-locked containers, carts or rooms". During an interview on 2/06/25 at 10:30 a.m. the Executive Director and DHW confirmed the Morphine should have been double locked, per program policy. 2. Record review for Tenant C-1 revealed an incident report dated 8/24/24 regarding an unwitnessed fall with injury. Staff entered the room at 7:40 a.m. and found Tenant C-1 on the floor, bleeding from his head. A progress note dated 8/24/24 written by the ADHW indicated she received a call from staff at 8:12 a.m. regarding Tenant C-1's fall around 7:40 a.m. Staff reported Tenant C-1 hit his head and was bleeding. The ADHW directed staff to contact Tenant C-1's	A 150		

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A 150	Continued From page 2 hospice nurse to evaluate the tenant. The hospice nurse arrived at the program a short time later and Tenant C-1 went to the emergency room, where he received staples for a head laceration. The progress note indicated 32 minutes passed from when staff found Tenant C-1 on the floor bleeding until they called the program nurse to inform her. A hospice nursing note dated 8/26/24 indicated Tenant C-1 had a head laceration with nine staples. When interviewed on 2/04/25 at 1:15 p.m. Staff B stated she assisted a second staff person with Tenant C-1 on the morning of 8/24/24. When asked why staff didn't notify the program nurse immediately of the fall with head injury, Staff B said the staff focused on cleaning up the blood first. She said Tenant C-1 didn't appear to be seriously hurt. Program policy entitled, "Fall with Possible Head Injury" indicated if a resident fell and hit their head on a solid surface, the nurse in charge would be notified immediately. During an interview on 2/05/25 at 3:40 p.m. the Executive Director and DHW confirmed staff failed to immediately notify the on-call nurse of Tenant C-1's fall with head injury on the morning of 8/24/24, in accordance with policy.	A 150		
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	A 160		

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A 160	Continued From page 3 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 care and services for 1 of 1 current (Tenant #5) and 1 of 1 former (Tenant C-1) tenants reviewed who had falls with significant injuries. Finding follows: 1. Record review revealed Tenant C-1 was 94 years old with diagnoses including essential hypertension, Type 2 diabetes, chronic atrial fibrillation, history of falling, fracture of unspecified parts of lumbosacral spine and pelvis, long term use of anticoagulants and weakness/muscle weakness. His Global Deterioration Score (GDS) was 6, indicating severe cognitive decline. Tenant C-1 was admitted to hospice care on 7/18/24. An incident report dated 8/24/24 indicated Tenant C-1 had an unwitnessed fall with injury. Staff entered the room and found Tenant C-1 on the floor, bleeding from his head. Tenant C-1 went to the emergency room, where he received nine staples for a head laceration. A progress note dated 8/28/24 written by the Assistant Director of Health and Wellness (ADHW) noted the incident on 8/24/24 and indicated 30 minute checks were initiated upon Tenant C-1's return to the program later in the day. The progress note also indicated the ADHW evaluated Tenant C-1 on 8/25/24 and examined his injury. She documented to continue 30 minute checks.	A 160	Tenant C-1 and Tenant # 5 no longer reside in the community. The Director of Health and Wellness (DOHW) re-educated Health and Wellness staff on 3/12/2025 regarding providing care based on nurse instructions and Fall prevention interventions. The Director of Health and Wellness (DOHW) also educated Health and Wellness staff on requesting assistance from co-workers when needed on 3/12/2025. The Community initiated a memory care wellness check three times per shift for all our memory care tenants on 3/7/2025. Those checks are part of the Tenants' specific updated service plans. The Director of Health and Wellness or Designee will perform a random audit weekly for the next 3 months to ensure that fall prevention interventions are part of the tenant's service plan when indicated and being followed and that the Memory Care Wellness checks are part of the Tenant's service plan.	4/4/2025

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A 160	Continued From page 4 The nursing progress note dated 8/28/24 indicated the ADHW received a call on 8/27/24 at 5:55 a.m. from staff, informing her Tenant C-1 was found on his bathroom floor with injuries. Tenant C-1 was bleeding from a skin tear to his left upper leg and complaining of bad right hip pain. The caregiver staff reported she had last checked on the tenant at 4:00 a.m. because she got caught up assisting another resident. The ADHW notified the hospice nurse of the incident, who went to the program to assess Tenant C-1. After consultation with family, the decision was made not to send the tenant out for medical assessment and treatment, but to provide comfort care and adjust medications. A nursing progress note on 8/29/24 noted Tenant C-1 passed away that morning. During an interview on 2/04/25 at 2:45 p.m. Staff C verified she was the overnight staff who found Tenant C-1 on the floor on the morning of 8/27/24. She recalled walking into Tenant C-1's room shortly before 6:00 a.m., which was the end of her shift. Tenant C-1 was on the floor which was covered with urine and feces. Staff C said she thought the tenant might have slipped and fallen. She said she last checked Tenant C-1 around 4:00 a.m. Staff C acknowledged she knew Tenant C-1 was supposed to have staff checks every 30 minutes, but she was busy with other tenants during that time. She said she was not able to check on Tenant C-1 every 30 minutes. During an interview on 2/05/24 at 3:40 p.m. the Executive Director and Director of Health and Wellness (DHW) confirmed staff failed to provide 30 minutes checks for Tenant C-1 on the morning of 8/27/24 when he fell and sustained injuries.	A 160		

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A 160	Continued From page 5 2. Record review revealed Tenant #5 was 77 years old with a diagnoses including Parkinson's disease; obesity; edema; unspecified cirrhosis of liver; obstructive sleep apnea; other specified disorders of bone density and structure, right thigh; and progressive supranuclear opthalmoplegia (limited ability to move eyes). He had a Do Not Resuscitate (DNR) code in place. Tenant #5 was not under hospice care. According to an occupational therapy (OT) note dated 1/28/25, Tenant #5 worked with OT to improve balance, mobility, transfers and bed mobility. An incident reported dated 1/31/25 indicated Tenant #5 lost his balance while standing and holding his walker, while trying to turn around to adjust his feet. The staff person present (Staff D) was unable to break the fall because he was holding onto the wheelchair. Tenant #5 fell backwards, onto his right side, hitting his head on the floor. Staff D called 911 and notified the on-call nurse. Tenant #5 was later transferred to the University of Iowa Hospital and Clinics (UIHC) due to the extent and severity of his injuries. According to information from UIHC, Tenant #5 had bilateral subdural hemorrhage, subarachnoid hemorrhage with large intraparenchymal hemorrhage with associated midline shift of 1.6 cm. He also had rib fractures 2 through 6, manubrial (sternum) fracture, L4 compression fracture as well as a C3/4 osteophyte fracture. Tenant #5's most recent assessment dated 12/03/24 indicated he needed cueing/standby assistance during transfers, but could stand independently. He was noted to be non-ambulatory. The assessment noted recent falls (review of incident reports revealed falls without injury in July, November, December and	A 160		

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A 160	Continued From page 6	A 160		

mid-January.) The assessment indicated Tenant #5 was participating with PT (physical therapy) and OT and his strength and transfers had improved with therapy. Tenant #5 scored as cognitively intact with stable cognition.

Tenant #5's most recent service plan dated 12/03/24 noted the plan was updated on 5/30/24 to indicate he was non-ambulatory. The prior update on 4/18/24 noted he needed cueing and standby assistance as needed for ambulation. The transfer section of the plan was last updated 5/30/24 and indicated Tenant #5 needed cueing/standby assistance for transfers. Transfer times were listed as early AM, mid AM, afternoon and bedtime. The plan noted mobility equipment should be nearby before transfer.

During interview on 2/04/25 at 11:25 a.m. Staff D said he went to Tenant #5's room on the morning of 1/31/25 to get him up. Staff D explained and demonstrated what happened in Tenant #5's room. He went to the side of Tenant #5's bed to wake him and assist him to sit up with his legs over the side of the bed. Staff D placed the walker in front of Tenant #5 and he stood up, holding onto the walker. The area between the bed and wall was narrow, providing little room to maneuver. Staff D said Tenant #5 began to turn his body and walker to the left, by moving his feet, so his backside would be facing the wheelchair when Staff D brought it to him. Staff D walked away from Tenant #5 to get the wheelchair, which was approximately 6 feet from the tenant. He got behind the wheelchair to move it to the tenant, when Tenant #5 fell backwards (toward the wheelchair) on his right side. Tenant #5 was turning around to his left when he fell. Staff D said Tenant #5 continued to hold onto the walker as he fell. He fell to the hard surface floor and hit his

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A 160	Continued From page 7 head. Staff D said he saw blood coming from the tenant's nose. Tenant #5 was breathing, with eyes open, but did not respond to Staff D. Staff D called 911 and the on-call nurse. Emergency services arrived to transport Tenant #5 to the hospital. During interview on 2/06/25 at 8:45 a.m., the occupational therapist said she had seen a decline in Tenant #5's physical ability in the past year. She said standby assistance meant staff should have been in arm's reach of him. During interview on 2/06/25 at 10:30 a.m. the Executive Director and DHW did not dispute the the program failed to meet Tenant #5's needs during transfer at the time of the incident on 1/31/25.	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 observation, interview and record review, the program failed to ensure medications and treatments were administered as prescribed for 3 of 7 tenants with reviewed medications.	A 285		

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A 285	Continued From page 8 Findings follow: 1. On 1/14/25 at approximately 8:00 a.m. observation revealed Staff A applied Absorbase ointment to Tenant #7's arms during the morning medication pass. Record review revealed Tenant #7's physician's orders dated 12/13/24 for Absorbase ointment to be applied two times daily to BLE (bilateral lower extremities). Tenant #7's January Medication Administration Record (MAR) provided the same information regarding the ointment. 2. On 1/14/25 at approximately 8:10 a.m. observation revealed Staff A set up Tenant #6's morning medications. Staff A handed the medication blister cards to the surveyor before popping the pills into a medication cup. The surveyor noticed two Acetaminophen tabs in each dosage slot of the medication card. The medication card and MAR both indicated one tablet to be administered. The surveyor questioned the discrepancy and Staff A put only one Acetaminophen tablet in the medication cup. She indicated she would notify the nurse. Three of the slots on the medication card were empty, indicating the medication was given the previous three days. Record review revealed Tenant #6's current 90-day physician's orders indicated Acetaminophen 325 mg, take one tab twice daily. The January MAR showed the Acetaminophen was given on the three days prior to 1/14/25. No documentation could be located to indicate the medication discrepancy was noted prior to the morning of 1/14/25. On 1/16/25 at 12:15 p.m. the Director of Health	A 285	Tenant #7's physician was notified of the error on 3/14/2025. A medication error report was completed on 3/14/2025, and no new orders were received at the time of the notification. Tenant #6's physician was notified of the error on 3/14/2025. The incorrect blister card was replaced with the correct one. An incident report was completed on 3/14/2025, and no new orders were received at the time of the notification. Tenant #2's physician was notified of the error on 3/14/2025. A medication error report was completed on 3/14/2025, and no new orders were received at that time. The order for Clonazepam was clarified with the attending physician, and the blister pack containing 1 mg was removed from the narcotic drawer. A new process was initiated at the community on 3/12/2025. Nurses will review the accuracy of medications received for tenants under medication management before delivery to the designated neighborhoods. The Director of Health and Wellness educated staff on proper medication administration and the new process for reviewing medications on 3/12/2025. For the next three months, the pharmacy consultant and/or the Director of Health and Wellness will observe random staff weekly during medication administration to ensure compliance with the requirements.	4/4/2025

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A 285	Continued From page 9 and Wellness (DHW) confirmed the information above regarding Tenant #6's Acetaminophen and Tenant #7's Absorbase ointment. 3. Record review revealed Tenant #2 received incorrect doses of Clonazepam in November 2024. Comparison of the MAR and narcotic (narc) count sheets revealed conflicting information. According to the MAR, staff documented they administered 0.5 mg Clonazepam to Tenant #2 on November 12th, 13th and 14th (per physician's orders), but they documented on the 1 mg narc sheets for those three days. Review of the narc count sheets for the 0.5 mg Clonazepam and 1 mg Clonazepam revealed the staff must have given 1 mg tablets on November 12th through 14th. On 2/04/25 at 9:45 a.m. the DHW verified records showed Tenant #2 received incorrect doses of Clonazepam for the three identified days in November 2024.	A 285		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced	A 350		

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A 350	Continued From page 10 by: Based on interview and record review, the program failed to include all service needs in 2 of 5 tenant service plans reviewed (Tenant #1 and Tenant #3). Findings follow. 1. On 2/05/25 record review revealed Tenant #1's most recent assessment dated 11/18/24, indicated he needed verbal cueing/stand-by throughout meals and two person assistance for transfers. Tenant #1's most recent service plan dated 11/18/24, contained no information regarding service needs for transfers. The dining section of the service plan indicated Tenant #1 needed reminders about meal times, but no information regarding service needs related to eating/dining. During an interview on 2/05/25 at 10:20 a.m. the Director of Memory Care confirmed Tenant #1's service plan contained no information regarding transfers or need for monitoring during meals. She said these services were no longer needed due to the tenant's improvement, however, there was no updated assessment or service plan to indicate the services were not needed. 2. On 2/04/25 record review revealed an Incident Report (IR) summary, which included information regarding Tenant #3's hospitalization on 12/07/24. The summary noted Tenant #3's history of risk for aspiration due to decline in swallowing ability. Tenant #3 resided in the Grand Living Assisted Living program prior to hospitalization on 12/07/24. He moved to the Memory Care program on 1/02/25. A nursing progress note dated 12/13/24 indicated Tenant #3 was admitted to the hospital, with plans	A 350	Tenant #1 assessment and services were updated on 2/6/2025 to include all service needs. Tenant #3 assessment and service plans were updated on 2/5/2025 to include all service needs. The Executive Director re-educated the Director of Health and Wellness (DOHW) and the Assistant Director of Health and Wellness (ADOHW) about the requirements for service plans on 3/12/2025. The re-education included addressing the specific needs of each individual tenant and updating the plans to reflect any significant changes or whenever changes are needed. The Director of Health and Wellness or Designee will perform random weekly audits for the next three months to ensure that service plans reflect residents' needs and are updated at least annually and whenever changes are needed.	4/4/2025

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A 350	Continued From page 11 to go to skilled care and an eventual return to the Grand Living Memory Care program with hospice care. Tenant #3's record contained a progress note by a physician dated 12/18/24, which indicated the tenant was in a skilled nursing facility. According to the progress note, Tenant #3 was treated for aspiration pneumonia and was at high risk for aspiration. The family did not want to pursue tube feeding. The doctor recommended Tenant #3 follow a diet that reduced his risk and to continue speech therapy and chin tuck to reduce aspiration with swallowing. Tenant #3's physician's orders dated 12/30/24 listed his diet as general and also recommended speech therapy for evaluation and treatment. Tenant #3's initial assessment for the memory care program dated 12/31/24 indicated he was on a regular diet, with regular food texture. The assessment noted Tenant #3 was independent with dining and provided no further information regarding decreasing risk for aspiration. Tenant #3's initial service plan dated 12/31/24 contained no information regarding diet, dining ability, or service needs related to dining. An updated service plan could not be located as of 2/04/25. During interview on 2/04/25 at 10:30 a.m. the Assistant Director of Health and Wellness (ADHW) stated Tenant #3 and his wife wanted a regular texture diet. She said the tenant had the ability to cut up his food. When asked about speech therapy recommendations for eating, the ADHW indicated the program didn't have the recommendations, but would request a copy.	A 350		

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	S0401	A. BUILDING: _____ B. WING _____	C 02/11/2025

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A 350	Continued From page 12 On 2/06/25 the program provided a copy of the speech therapy evaluation completed 1/16/25. The evaluation noted the family declined to alter food and drink texture. The evaluation made multiple recommendations for strategies to decrease risk of aspiration, including modified cups, double swallows, chin tuck and single bites. The assessment noted the staff were educated regarding cues/strategies and an email was sent to the ADHW regarding strategies and oral cares. During an interview on 2/06/25 at 10:30 a.m. the DHW did not dispute the program failed to address the speech recommendations for the eating strategies to prevent the risk of aspiration.	A 350		
A 355	481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to develop an initial service plan by a health care or human service professional for 1 of 1 tenants reviewed who moved to the program within the past three months (Tenant	A 355		

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A 355	Continued From page 13 #3). Finding follows: On 2/04/25 record review revealed Tenant #3's initial service plan dated 12/31/24, with move in date of 1/02/25. The plan had an undated signature of Tenant #3's representative and the signature of the Assistant Director of Health and Wellness (ADHW) dated 1/15/25. During interview on 2/04/25 at 10:30 a.m. the ADHW confirmed she wrote/developed Tenant #3's service plan. The ADHW was a Licensed Practical Nurse (LPN), which does not meet the definition of a health care professional.	A 355	The Registered Nurse reviewed the service plan for Tenant #3 on 2/5/2025. The Executive Director provided training to the Director of Health and Wellness (DOHW) and the Assistant Director of Health and Wellness (ADOHW) on 3/12/2025 regarding the requirement that a healthcare provider or human resources professional develop a preliminary service plan. The community Registered Nurse or a qualified designee will review and update all Tenants' service plans as indicated by 4/4/2025. The Executive Director or Designee will audit random recent admissions weekly for the next three months to ensure that evaluation and service plans are developed by the Registered Nurse or a qualified Designee.	4/4/2025
A 405	481-69.26(4)c Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: c. The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide information in the service plan for outside services for 4 of 4 tenants reviewed on hospice (Tenant #1, Tenant #2, Tenant #3 and Tenant #4). Findings follow: 1. Review of Tenant #1's most recent assessment dated 11/18/24 revealed a change of condition due to admission to hospice care. The service plan dated 11/18/24 provided no information regarding hospice services or a hospice provider.	A 405		

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A 405	Continued From page 14 During interview on 2/05/24 at 10:20 a.m. the Director of Health and Wellness (DHW) confirmed the program failed to provide information regarding outside services in the service plan. 2. Review of Tenant #2's most recent assessment dated 11/15/24 revealed a change of condition with admission to hospice the same date. The service plan dated 11/15/24 noted hospice care, but failed to include the name of the agency or services provided. During interview on 2/04/25 at 4:30 p.m. the DHW confirmed the program failed to provide information regarding outside services in the service plan. 3. Review of Tenant #3's initial assessment dated 12/30/24 indicated the need to coordinate with hospice and home health. The initial service plan dated 12/31/24 noted the nurse would obtain updates from outside agencies, but failed to include information regarding the outside agencies or services provided. No updated service plan was available at the time of the record review on 2/04/25. During an interview on 2/04/25 at 10:30 a.m. the DHW confirmed the program failed to provide information regarding outside services in the service plan. 4. Review of Tenant #4's most recent assessment dated 12/30/24 indicated the tenant continued to receive hospice care and the hospice care worker could occasionally convince the tenant to shower. Tenant #4's service plan dated 12/30/24 noted hospice service, but failed to include the name of	A 405	Tenant #1service plan was updated to include hospice provider and hospice services on 2/6/2025. Tenant #2 service plan was updated to include the hospice provider and hospice services on 2/72025. Tenant # 3 service plan was updated to include the hospice provider and hospice services and information about a home health provider and home health services on 2/5/2025. Tenant #4 service plan was updated to include the hospice provider and hospice services on 3/14/2025. The Executive Director provided education to the Director of Health and Wellness (DOHW) and the Assistant Director of Health and Wellness(ADOHW) on 3/12/2025 regarding the requirement to include information about hospice providers, home healthcare, occupational therapy, physical therapy, and caregivers in tenants' service plans. The Director of Health and Wellness (DOHW) or Designee will conduct random audits weekly for the next three months to ensure that service plans include information and services provided for hospice providers, home healthcare, occupational therapy, physical therapy, and caregivers.	4/4/2025

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A 405	Continued From page 15 the agency or the services provided. During an interview on 2/05/25 at 11:30 a.m. the DHW confirmed the program failed to provide information regarding outside services in the service plan.	A 405		
A 420	481-69.27(1)a 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: a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to do quarterly nurse reviews that included review of medications for 3 of 3 tenants reviewed who resided in the program for over three months (Tenant #1, Tenant #2, Tenant #4). Findings follow: 1. On 2/05/25 record review revealed the program managed Tenant #1's medications. Tenant #1 moved to the program on 1/09/23. No nurse review of medications could be located in	A 420	Tenant #1 Nurse review was completed on 3/14/2025 to address prescription medications for adverse reactions to the medications and to make appropriate interventions and referrals to ensure that the prescription orders are current and administered consistently with orders. Tenant #2 Nurse review was completed on 3/14//2025 to address prescription medications for adverse reactions to the medications and to make appropriate interventions and referrals to ensure that the prescription orders are current and administered consistently with orders. Tenant# 4 Nurse review was completed on 3/14/2025 to address prescription medications for adverse reactions to the medications and to make appropriate interventions and referrals to ensure that the prescription orders are current and administered consistently with orders. The Executive Director on 3/12/2025 educated the Director of Health and Wellness (DOHW) and Assistant Health and Wellness Director (ADOHW) regarding the requirements of a nurse review for Tenants who receive program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions and referrals to ensure that the prescription orders are current and administered consistent with orders.	4/4/2025

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A 420	Continued From page 16 the tenant's record. During interview on 2/05/25 at 10:20 a.m. the Director of Health and Wellness (DHW) confirmed the lack of nurse review related to tenant medications. 2. On 2/04/25 record review revealed the program managed Tenant #2's medication. She moved to the program on 4/19/23. No nurse review of medications could be located in the tenant's record. During interview on 2/04/25 at 4:30 p.m. the DHW confirmed the lack of nurse review related to tenant medications. 3. On 2/05/25 record review revealed the program managed Tenant #4's medications. She moved to the program on 7/01/23. No nurse review of medications could be located in the tenant's record. During interview on 2/05/25 at 11:30 a.m. the DHW confirmed the lack of nurse review related to tenant medications.	A 420	By 4/4/2025, the Community will include in the nurse review of the resident's prescription medications for adverse reactions to the medications and to make appropriate interventions and referrals to ensure that the prescription orders are current and administered consistently with orders. The Director of Health and Wellness (DOHW) or their designee will conduct random audits weekly for the next 3 months to ensure that nurse review includes nurse review on the resident's prescription medications for adverse reactions to the medications and to make appropriate interventions and referrals to ensure that the prescription orders are current and administered consistently with orders.	
A 530	481-69.29(4) Staffing 481-69.29(231C) Staffing. 69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans.	A 530		

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A 530	Continued From page 17 A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to indicate how often to check tenants in service plans for 1 of 1 former tenants reviewed (Tenant C-1). Findings follow: Record review revealed an incident report dated 8/24/24 indicated Tenant C-1 had an unwitnessed fall with injury. Staff entered the room and found Tenant C-1 on the floor, bleeding from his head. Tenant C-1 went to the emergency room, where he received nine staples for a head laceration. A progress note dated 8/28/24 written by the Assistant Director of Health and Wellness (ADHW) noted the incident on 8/24/24 and indicated 30 minute checks were initiated upon Tenant C-1's return to the program later in the day. A nursing progress on 8/25/24 indicated the 30 minute checks should continue. Review of Tenant C-1's service plan in place at the time of the incident, dated 7/15/24, noted the tenant was a fall risk. The service plan indicated the program would provide safety checks related to fall risk, but failed to provide information regarding how often staff should check the tenant. The plan was not updated after the fall on 8/24/24 to include the 30 minutes checks.	A 530	Tenant C-1 is no longer residing at the Community. The Director of Health and Wellness (DOHW) re-educated Health and Wellness staff on 3/12/2025 regarding providing care based on nurse instructions and Fall prevention interventions. The Director of Health and Wellness (DOHW) also educated Health and Wellness staff on requesting assistance from co-workers when needed on 3/12/2025. The Community initiated a memory care wellness check three times per shift for all our memory care tenants on 3/7/2025. Those checks are part of the Tenants' specific updated service plans. The Executive Director and Director of Health and Wellness (DOHW) educated the Assistant Director of Health and Wellness on 3/12/2025 regarding updating the Tenant's service plan with the fall interventions and including the frequency of the interventions. Health and Wellness staff was educated on 3/12/2025 by Director of Health and Wellness on fall prevention interventions. The Director of Health and Wellness or Designee will perform a random audit weekly for the next 3 months to ensure that fall prevention interventions are part of the tenant's service plan when indicated and being followed and that the Memory Care Wellness checks are part of the Tenant's service plan.	4/4/2025

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A 530	Continued From page 18 During an interview on 2/05/25 at 3:40 p.m. the Vice President of Operations verified the frequency of tenant checks should have been indicated in his service plans. During an interview on 2/05/25 at 11:30 a.m. the DHW confirmed the service plan did not indicate the frequency of staff checks.	A 530		