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
	S0415	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE PLACE - CONNECTIONS	2115 1ST AVENUE SE CEDAR RAPIDS, IA 52402

(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. Tenants without cognitive impairment: 4 Tenants with cognitive impairment: 10 Total census: 14 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program.	A 000	see attached POC 11/13/25	
A 125	481-67.2(1)d Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: d. The incident report shall include statements from individuals, if any, who witnessed the incident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program incident report policy and procedure failed to reflect all required information which included witness statements. This potentially affected all tenants (census of 14). Finding follows: Record review on 9/15/25 revealed the Program's	A 125		

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A 125	Continued From page 1 Policy ,Resident Incident Management, revised March of 2025, indicated the policy failed to include information about statements from individuals who witnessed the incident. When interviewed on 9/17/25 at 3:54 p.m. the Assisted Living Manager confirmed the current policy and procedure for incident reports was provided.	A 125		
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 medication and treatments as prescribed by the tenant's physician. This pertained to 2 of 3 tenants reviewed (Tenant #1 and Tenant #2). Findings follow: 1. Record review on 9/16/25 and 9/17/25 revealed Tenant #1's July and August 2025 Medication Administration Records (MARs) reflected an order for quetiapine fumarate oral tablet 25 milligram (mg), take 0.5 mg tablet by	A 285		

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A 285	Continued From page 2 mouth two times per day. The medication was documented as not administered due to not being available ten times in July and one time in August. The August MARs reflected an order for Meloxicam oral tablet 7.5 mg, take one tablet by mouth one time per day. The medication was documented as not administered due to not being available 12 times in August. 2. Record review on 9/16/25 revealedTenant #2's August and September 2025 MARs reflected an order for Voltaren External Gel 1%, applied to affected areas topically, four times per day. The gel was documented as not administered due to not being available 13 times from 8/30/25 to 9/2/25. Record review on 9/16/25 revealed the Program's Medication Administration policy, dated 10/28/20, indicated all medications were administered following physician orders. When interviewed on 9/17/25 at 3:54 p.m. the Assisted Living Manager confirmed all MARs were provided for the tenants reviewed.	A 285		
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	A 140		

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A 140	Continued From page 3 by: Based on interview and record review the Program failed to complete evaluations within 30 days of taking occupancy. This pertained to 1 of 1 tenant reviewed who was due for a 30 day review (Tenant #1). Finding follows: Record review on 9/16/25 revealed Tenant #1's file indicated he was admitted on 5/16/25. Tenant #1's evaluations were completed on 5/16/25 and were not completed within 30 days of taking occupancy. When interviewed on 9/17/25 at 3:54 p.m. the Assisted Living Manager confirmed the above finding.	A 140		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed and failed to have service plans reflect the service needs of tenants. This pertained to 3 of 3 tenants reviewed (Tenant #1, Tenant #2 and	A 350		

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A 350	Continued From page 4 Tenant #3). Findings follow: 1. Record review on 9/16/25 of Tenant #1's file revealed Tenant #1 fell on 7/10/25 (head laceration with staples), 8/8/25 (skin tear) and 8/12/25 (skin tear). Continued record review of the Adult Services Monitoring Entrance Form completed by the Program identified Tenant #1 with wandering behaviors. Further record review revealed a Progress Note, dated 9/12/25 indicated Tenant #3's history of elopement at home and a history of attempting to leave without informing staff. He verbally expressed he wanted to go home, packed his belongings or stayed near the door. The note indicated his behavior of wandering (pattern or goal-directed). Continued record review revealed Tenant #1's service plan reflected there was an electronic wandering monitoring device on his ankle. The plan directed staff to check the device's function on day shift and the device's placement on all shifts. The service plan indicated Tenant #1 ambulated independently with a walker. The service plan failed to reflect Tenant #1's history of falls with interventions and his wandering behavior. 2. Record review on 9/16/25 of Tenant #2's file revealed the reflected staff administered her medications. Observation on 9/15/25 at approximately 4:00 p.m. revealed Staff C prepared Tenant #2's medication, acetaminophen oral tablet 325 milligram (mg), gave 650 mg by mouth, three	A 350		

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A 350	Continued From page 5 times per day for pain. Staff C crushed the acetaminophen tablets and placed the crushed medications in pudding prior to administering her medications. Continued record review revealed an email from the Assisted Living Manager indicated Tenant #2 did not have an order for crushed medications; however, she demonstrated her preference for the medication to be crushed. Further record review revealed Tenant #2's service plan failed to reflect that the acetaminophen tablets were to be crushed. 3. Record review on 9/16/25 revealed Tenant #3's service plan, dated 9/9/25 reflected Tenant #3 was usually continent but did have incontinence at night. The plan noted protective undergarments would be attempted with the move to the Program. He needed assistance with dressing and undressing. Staff attempted to change his clothes daily in the a.m. and p.m. Staff assisted twice weekly with bathing. He needed a lot of reassurance and might require different attempts. When interviewed on 9/16/25 at 10:32 a.m. Staff A said three staff were used to change Tenant #3 yesterday. She indicated he was incontinent of urine and staff were able to get him changed. Staff were able to get his pants pulled down when he was laying down and other staff were able to get his pants on before he became really agitated. She said staff tried to change him at least once per shift. When interviewed on 9/16/25 at 11:12 a.m. Staff B said Tenant #3 required assistance changing his clothes. Tenant #3 said no at first when staff	A 350		

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A 350	Continued From page 6 checked on him then staff checked back within 30 minutes. It took one to two staff to assist him. Continued record review revealed a fax dated 9/13/25, sent to the provider indicated the family was requesting a medication (lorazepam) to have as needed to help with calming him for activities of daily living. Tenant #3 was combative when cares were attempted. The fax noted cream would be best due to him being unlikely to take the pill unless it was with other medications. An order was received for lorazepam 0.5 mg, applied topically to the skin every four hours as needed. It was noted on 9/15/25. Further record review of the Adult Services Monitoring Entrance Form completed by the Program identified Tenant #3 with wandering behaviors. Continued record review revealed a Progress Note dated 9/10/25 indicated Tenant #3's history of elopement when at home and a history of attempting to leave without informing staff. He verbally expressed wanted to go home, packed his belongings or stayed near the door. It indicated he wandered. Further record review revealed Tenant #3's service plan failed to be updated to reflect the combativeness with cares, interventions related to the behavior and incontinence and assistance with managing the incontinence. The service plan reflected a Global Deterioration Scale (GDS) of six and wore an electronic wandering monitoring device. The service plan failed to reflect his wandering behaviors. When interviewed on 9/17/25 at 3:54 p.m. the Assisted Living Manager confirmed all service	A 350		

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A 350	Continued From page 7 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 service plans within 30 days of taking occupancy. This pertained to 1 of 1 tenant reviewed admitted in 2025 and due for a 30 day review (Tenant #1). Findings follow: 1. Record review on 9/16/25 of Tenant #1's file revealed he was admitted on 5/16/25. A service plan was developed dated 5/16/25. A service plan was not developed within 30 day of taking occupancy. 2. When interviewed on 9/17/25 at 3:54 p.m. the Assisted Living Manager confirmed the above finding.	A 360		

COTTAGE GROVE PLACE – Assisted Living - CONNECTIONS

PLAN OF CORRECTION

DEFICIENCY / TAG Date of compliance 11/13/25	Plan of Correction
A125 – Policies & Procedures	1. Corrective Actions: • Policy/Procedures updated to include mandatory witness statements for all tenant and staff incidents. • Staff retrained on proper incident documentation and collection of witness details. • Revised incident report form implemented with a designated witness statement field. 2. Measures to Ensure the Problem Does Not Recur: • Witness-statement requirements integrated into onboarding and Annual Inservice training. • RN Supervisors to review each incident report for completeness prior to final submission. • Target Date for Correction: 11/13/25 3. Monitoring for Compliance: • Monthly RN/Designee audits of all incident reports for six months and thereafter.
	• Falls and Documentation review add to ALP/ALMC QAPI meetings
A285 – Medication	1. Corrective Actions: • All staff in-serviced on medication-pass expectations and MAR documentation accuracy.

	• Medication availability checklist implemented to verify meds at the start of each shift. 2. Measures to Ensure the Problem Does Not Recur: • Shift-to-shift medication availability review implemented. • Quarterly medication-pass refresher training established for all staff. • Target Date for Correction: 11/13/25 3. Monitoring for Compliance: • Weekly MAR audits for 90 days, transitioning to monthly audits for 6 months. • Medication Administration Monitoring is added to ALP/ALMC QAPI meetings for review.
A140 –Evaluation of Tenant	1. Corrective Actions: • Admission checklist revised to include 30-day evaluation deadlines. • Responsible RN was provided education on completion of required assessment and evaluation documentation timely. 2. Measures to Ensure the Problem Does Not Recur: • RN/designee will review the admissions tracking log weekly to ensure timely completion. • Staff retrained on the regulatory requirement and timeline for 30-day evaluations. • Target Date for Correction: 11/13/25 3. Monitoring for Compliance: • Monthly audits of new admissions for six months and ongoing thereafter to confirm completion within regulatory

	timeframes.
A350 – Service Plans	1. Corrective Actions: • All service plans reviewed and updated immediately to ensure accuracy and regulatory compliance. • RN/Designee completed Inservice training with all staff regarding service plan accuracy, medication administration, and ADLs. • Weekly interdisciplinary review process initiated for service-plan updates. 2. Measures to Ensure the Problem Does Not Recur: • Staff retrained on service-plan documentation, including timely updates following changes in condition. • Target Date for Correction: 11/13/25 3. Monitoring for Compliance: • Weekly audits for 90 days, then monthly audits for 6 months thereafter to ensure accurate service-plan update. • Service Plan review added to ALP/ALMC QAPI meetings
A360 – Service Plan	1. Corrective Actions:. • Admission tracking tool updated to flag service plans due within 30 days. • RN/Designee completed training related to completion of service plans timely and accurately. 2. Measures to Ensure the Problem Does Not Recur: • Weekly clinical huddles implemented to review new

	admissions and ensure all 30-day deadlines are met. • Staff retrained on service-plan timing requirements and regulatory expectations. • Target Date for Correction: 11/13/25 3. Monitoring for Compliance: • Monthly audits for six months and Service Plan is added to ALP/ALMC QAPI meetings