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
	16427_hfd	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	**5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411**

(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 disorder: 0 Number of tenants with cognitive disorder: 38 Total Census of Assisted Living Program for People with Dementia: 38 Complaints #124433-C, #126483-C and Incidents #124858-I and #125225-I were investigated and the following regulatory insufficiencies were identified:	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 its policy and procedure related to admission and retention criteria. This pertained to 1 of 9 current tenants reviewed (Tenant #2) and 1 of 3 discharged tenants reviewed (Tenant C2). Findings include: 1. On 2/24/25 review of Tenant #2's file revealed Observations (nurse's notes) indicating the following: - On 12/17/24 the service plan was updated to reflect Tenant #2 needed the assistance of two staff with transfers, showers and toileting. - On 12/17/24 yelled at staff while doing cares for him.	A 150	The Plan of Correction is attached	

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

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- On 12/20/24 wheeled himself over to a female staff and said staff needed to lay on the floor and made a comment about his genitals. He continued to try and get staff to engage in sexual activities.
- On 12/20/24 an incident report was completed related to behavior.
- On 12/23/24 the Interim Nurse indicated she was back in the building, went through observations and spoke with staff. She spoke with the Executive Director about Tenant #2's behaviors and the need for this family to be given a 30 day notice.
- On 12/25/24 yelled at staff and kicked the front the door of the office and demanded staff open the door. Staff had been trying to redirect him but it was not working.
- On 12/26/24 did not allow staff to do any cares. He also hit and kicked the doors to the facility.
- On 12/27/24 found "bottomless" in a female tenant's apartment touching her arm. Staff removed him from the apartment.
- On 12/27/24 refused all cares from staff after multiple attempts from different staff. He also refused to eat lunch.
- On 12/28/24 refused all cares from staff. He yelled at staff and threatened to hurt them.
- On 12/29/24 incontinent of bowel and bladder that morning. While trying to change him, he swung his fists at staff and started yelling. It took four staff to clean him up due to him not wanting to stand. He would only stand for 10 seconds before he said to let him down as he could not stand any longer.
- On 1/2/25 refused all cares.
- On 1/4/25 refused all cares from staff.
- On 1/6/25 yelled and screamed at staff as they tried to toilet him that morning.
- On 1/7/25 came out of his apartment without clothing and had a blanket on his lap. Staff told

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him they were going to take him to his apartment to get him dressed. He "braced his feet to the ground" and called staff names.
- On 1/7/25 the Interim Nurse spoke with the Executive Director about Tenant #2's continued behaviors and the need for a 30 day notice. The Executive Director said she was working on it.
- On 1/9/25 came out of his apartment with just a protective undergarment on. Staff said he needed to go back to his apartment to put on clothing. He told staff he was not going to do it. He told staff to lay down on the floor and made a comment about his genitals.
- On 1/24/25 as staff tried to change him he started yelling and hitting staff. It took three staff to change him.
- On 1/28/25 yelled and fought with staff while they took him to the bathroom. It took three staff to complete the task.
- On 1/29/25 it was noted the Executive Director was still working on the 30 day notice for Tenant #2 due to his continued behaviors.
- On 2/1/25 was very aggressive when staff assisted with a shower. He hit, scratched and yelled.
- On 2/10/25 required the assistance of two people for transfers. He was very aggressive, hit and was bit staff.
- On 2/13/25 fighting, biting and was very aggressive.
- On 2/15/25 an incident report was completed regarding tenant to staff behavior.
- On 2/17/25 went out to the hospital due to low oxygen and heart rate and was admitted on 2/18/25 for aspiration pneumonia.
- On 2/20/25 moved to a hospice house and was discharged.

A review of incident reports revealed the following:

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A 150	Continued From page 3 - On 12/20/24 staff was trying to assist him with changing and going to the bathroom. He started to get aggressive with staff while they tried to help. Tenant #2 grabbed staff by the shirt and hit staff in the back of the shoulder. - On 12/26/24 while staff was attempting to assist Tenant #2 with going to the bathroom he got upset and started to scream and hit staff while doing cares. - On 12/28/24 as staff attempted to help Tenant #2 with toileting he became upset and started to hit staff. Another staff walked in and tried to help. He yelled at both staff. - On 2/15/25 while staff was getting Tenant #2 into his bed he became angry at staff. When staff moved him on the bed, he scratched staff across the face with his nails. When interviewed on 2/24/25 at 1:51 p.m. Staff B said Tenant #2 required the assistance of two staff for a few months. Tenant #2 also had behaviors and would scream and try to hit staff. On 2/24/25 at 4:29 p.m. Staff C said Tenant #2 had sexual and verbal behaviors. He also required the assistance of two people with transfers. When interviewed on 2/25/25 at 10:10 a.m. Staff D said Tenant #2 was very difficult. He required the assistance of two to three staff for transfers for a long time, possibly six months. When interviewed on 2/25/25 at 10:47 a.m. Staff E said Tenant #2 required the assistance of two people for the last two months. She said he required the assistance of two people for everything. On 2/24/25 at 3:23 p.m. Staff F said Tenant #2	A 150		

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required the assistance of two people 100 % of the time. He also started having behaviors towards the end.

When interviewed on 2/25/25 at 4:02 p.m. Staff G said Tenant #2 was normally in his wheelchair, and he required the assistance of two people.

When interviewed on 2/25/25 at 1:32 p.m. the Interim Nurse said Tenant #2 required the assistance of two people in December.

Further review of Tenant #2 record revealed he was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. No 30 day notice related to his 2 person assist transfers or his behaviors could be located despite exceeding level of care.

2. On 2/20/25 review of Tenant C2's Observations (nurse's notes) indicated the following:
- On 10/24/24 the PCP was contacted regarding his sexual behaviors and new orders were received to discontinue escitalopram and start fluoxetine 40 milligram (mg), every day.
- On 10/25/24 family requested Tenant C2 remain on escitalopram at the increased dose of 20 mg daily, and to discontinue fluoxetine and start duloxetine.
- On 11/4/24 behavior continued despite medication changes and redirections. The "behavior cannot be tolerated in facility." A fax and text message were sent to the PCP.
- On 11/4/24 a new medication had been prescribed by the memory clinic that had been communicated to the Program.
- On 11/4/24 medication change to depakote sprinkles 250 mg, twice daily for behaviors. Family reported Tenant C2 was at a family event recently and he was observed hugging and

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getting into other's personal space. It was not typical for Tenant C2.

- On 11/19/24 new orders were received for depakote 500 every morning and 250 mg every evening.
- On 12/3/24 staff walked down the hall and observed Tenant C2 coming out of Tenant #1's apartment with his pants down and his belt in his hand. Staff asked what he was doing in that apartment and he said "I'm trying to have sex." Tenant C2 also said "I don't know what I am doing." Staff helped him get dressed in his apartment and took him to breakfast.
- On 12/5/24 lab work and urinalysis (UA) returned within normal limits. A new order was received to change divalproex to 500 mg twice daily.
- On 12/11/24 after supper, staff stopped Tenant C2 from going into Tenant #1's apartment. He said for staff to come in with him and have fun. When staff refused to enter his apartment, he tried to grab staff's waist and he insisted they enter his apartment. Staff kept their distance and explained it was not respectful to touch people inappropriately. He said he knew but continued to reach out towards staff's breast and his hand was stopped. He was told not to touch staff and said he did not care and wanted to go and "have fun." Staff told him to go to his apartment and turn the lights on. He made a comment that he wanted "turn them on" and grabbed his genitals. Tenant C2 went to his apartment after additional attempts to touch staff inappropriately.
- On 12/12/24 chased staff around the dining room and became aggressive when other staff tried to intervene.
- On 12/19/24 the memory care clinic called asking for an update. It was reported Tenant C2 was being treated for a urinary tract infection (UTI) and his last dose of antibiotics was

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tomorrow. He continued to be resistant to cares and became aggressive with staff.
- On 12/19/24 during a group wellness class Tenant C2 could not keep his hands to himself. He grabbed the wrist of the female tenant next to him and touched her head. He also playfully hit other tenants with the foam noodle. Redirection was attempted several times and he would scowl and continue his behavior.
- On 12/24/24 when staff administered his medications he told staff to give him a kiss. Staff said no and tried to leave the bathroom. Tenant C2 blocked the door with his body, his arms were spread out and tried to grab staff. Staff repeatedly said no and he kept asking why staff did not want to have fun. He raised his fist as if he was going to hit staff and then backed down. He still blocked the bathroom door exit.
- On 12/27/24 tried to kiss staff while administering his medications.
- On 12/27/24 new orders were received to discontinue escitalopram and start fluoxetine.
- On 12/29/24 had low blood pressure, complained of pain in his abdomen, feet and legs. He had a swollen left foot and legs. He had slurred speech and little movement.
- On 12/29/24 family decided to take him to the ED for evaluation.
- On 1/18/25 it was noted Tenant C2 died.

A review of incident reports revealed the following:
- On 10/23/24 at 4:00 p.m. Tenant C2 entered Tenant #1's apartment and approached her while she sat in her recliner. He put his hand on her neck and made sexual comments.
- On 11/4/24 while staff was administering medications he came up behind her, grabbed her arms and said "kiss, kiss, kiss." He would not let go.

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- On 12/2/24 he was observed by staff groping Tenant #1's thigh and moving his hand toward her genitals. He was redirected to his apartment immediately. Staff would complete hourly checks to ensure he stayed in his apartment.
- On 12/16/24 while staff was cleaning his bathroom, he came up behind her, put both hands on the counter on either side of her and moved his body against hers. She told him to sit down to remove himself from her. He refused but the staff was able to remove herself and reported it.

When interviewed on 2/24/25 at 1:51 p.m. Staff B said Tenant C2 had been sexually inappropriate towards staff and tenants every few days.

When interviewed on 2/24/25 at 4:29 p.m. Staff C said Tenant C2 had displayed sexual behavior but not aggressive behavior.

On 2/25/25 at 10:10 a.m. Staff D said Tenant C2 had displayed inappropriate behavior towards staff and tenants quite often

When interviewed on 2/24/25 at 3:23 p.m. Staff F said Tenant C2's behaviors started before she started working there. They seemed to increase between September and December. She said Tenant C2 had cornered staff in the apartment and tried to put himself on her. He had also cornered a staff passing medication and tried to push her head towards his genitals. She said his medications were adjusted but were not effective.

Further record review revealed Tenant C2 had a diagnosis of unspecified dementia and was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. A fax to the PCP dated 11/4/24 indicated

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Tenant C2's behavior had not changed and had worsened despite medication changes. Tenant C2 followed, groped and made inappropriate comments towards other tenants and staff. The behavior was "predatory, becoming aggressive" and was not within the regulations for assisted living. Review of Tenant C2's file revealed a 30 day notice could not be located related to behaviors; despite Tenant C2 exceeding level of care.

4. On 2/19/25 review of the Program's tenant retention policy located in the Occupancy Agreement indicated the Program would terminate the agreement and start procedures to ensure a safe and orderly transfer including for the following conditions:
- Required routine, two-person assistance with transfers, standing or evacuation and despite intervention chronically elopes, was sexually or physically aggressive or abusive and displayed unmanageable verbal abuse or aggression.

5. When interviewed on 2/27/25 at 10:20 a.m. the Executive Director said Tenant #2 often had UTIs and became difficult to handle. She had a 30 day notice prepared but it was not given to Tenant #2's family. She also confirmed a waiver was not applied for regarding Tenant #2. Regarding Tenant C2, a 30 day notice had not been given but they were working closely with family. He then became bed bound/wheelchair bound and passed away.

In summary, Tenant #2 and Tenant C2 were discharged by the time of the conclusion of the onsite visit. Staff interviews, incident reports, nurse's notes and documentation in the tenant files indicated Tenant #2 and Tenant C2 exceeded the level of care as indicated in the

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A 150	Continued From page 9 Program's policy and procedure. There were no 30 day notices provided related to Tenant #2 or Tenant C2 exceeding the level of care. The Program did not follow its policy and procedure related to level of care.	A 150		
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: Interview and record review revealed the Program failed to administer medications and treatments as ordered. This pertained to 6 of 9 current tenants reviewed (Tenant #1, #2, #3, #6, #7 and #8) and 2 of 3 discharged tenants reviewed (Tenant C1 and C2). Findings follow: 1. On 2/24/25 review of Tenant #1's file revealed an After Visit Summary (AVS) dated 1/31/25 indicating Tenant #1 was seen for Influenza A and dehydration during a visit to the emergency room. Orders were received to take Tamiflu 1 capsule 75mg (milligrams) twice daily for 5 days, and Tylenol 650 mg, four times per day for the next three days and then as needed. Review of Tenant #1's January and February	A 285		

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A 285	Continued From page 10 2025 medication administration records (MARs) did not reflect the orders or administration of Tamiflu or Tylenol as ordered. The February MAR also revealed the tenant's levothyroxine 88 microgram (mg) tablet, taken at 7:00 a.m. daily, was documented as not available to administer from 2/4/25 to 2/11/25. A daily multivitamin was not administered from 2/8/25 to 2/11/25 as it was not available to administer. The Scheduled Medications Notations indicated it was not delivered yet as they were waiting for family to bring it in. 2. On 2/24/25 review of Tenant #2's file revealed the January 2025 MAR reflected Desenex 2% powder was to be applied topically twice daily in groin and perineal area. The powder was documented as not administered 35 times. Scheduled Medication Notations from 1/4/25 to 1/31/25 indicated the medication was not delivered by pharmacy. There were also some entries charted as refused, for example on 1/4/25 it was charted as refused at 8:06 a.m. and medication not available on 1/4/25 at 7:44 p.m. It was also documented as administered 19 times between 1/4/25 to 1/31/25 despite entries regarding the medication not available to administer. For example, on 1/17/25 at 7:29 a.m. it was charted as not administered due to the medication not being available. It was then charted as administered on 1/17/25 (p.m. dose) and on 1/18/25 at 7:46 a.m. it was charted as not administered due to the medication not being available. The tenant's February 2025 MAR reflected the Desenex powder was documented as not administered 9 times from 2/1/25 to 2/16/25. The Scheduled Medication Notations indicated either	A 285		

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the medication was not available from pharmacy; other; tenant refused; or not in the medication cart. There were 5 omissions where no initials were charted from 2/1/25 to 2/16/25.

3. On 2/24/25 review of Tenant #3's file revealed the January and February 2025 MARs revealed the following medications were not available to administer:
- Diclofenac Sodium 1% gel, apply 4 gm, to both knees twice per day, was documented as not delivered by pharmacy (nurse aware) on 1/28/25, 1/29/25 and 1/30/25.
- Donepezil HCL 10 mg, one tablet daily, was documented as not in the medication cart on 1/31/25
- Mirtazapine 7.5 mg, one tablet daily was documented as medication not available; not delivered from pharmacy; or other from 2/14/25 to 2/20/25.

4. On 2/25/25 review of Tenant #6's file revealed the February 2025 MAR reflected an order for Lidocaine pain relief 4% patch, to be applied to the low back daily. It was started on 1/7/25. It was charted as not administered five times from 2/16/25 to 2/25/25. Scheduled Medication Notations indicated it was not delivered from pharmacy.

5. On 2/25/25 review of Tenant #7's file revealed Observations (nurse's note) dated 2/3/25 indicating the tenant was crying as she walked to the dining area. When staff asked what was wrong, she said her legs and she began to rub them. It was noted Tenant #7 had an as needed order (PRN) for pain but the medication was not available.

Review of Tenant #7's February MAR revealed an

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order dated 12/12/25 for acetaminophen 500 mg, 2 tablets PRN. The MAR reflected no doses of PRN acetaminophen were administered including on 2/3/25, when Tenant #7 was crying as she walked and staff charted the PRN for pain was not available.

6. On 2/25/25 review of Tenant #8's file revealed Observations (nurse's notes) indicating the following:
- On 10/8/24 the nurse received a call at 1:00 a.m. from staff. A skin tear was present post fall (she was found on the floor). The nurse directed staff to send Tenant #8 to the ED (emergency department) as the wound was too "extensive" to be treated at the Program.
- On 10/21/24 staff went to complete Tenant #8's gauze wrap change at 8:30 a.m. The wrap appeared not to be changed despite the MAR showing it was changed. The gauze was "stuck and imbedded into wound, adhesive pad was by her wrist when it supposed to be at elbow level to protect wound and properly heal." Staff had to soak the wound for more than 20 minutes to remove the gauze without damaging the wound. Staff completed the dressing change and it was noted Tenant #8 was showing less signs of pain.

Tenant #8's November MAR reflected an order to change the dressing to the elbow, clean with saline, place a small amount of Vaseline on the non-adherent pad and cover with gauze. This was done on a daily basis. The order was started on 10/16/24 and discontinued on 11/21/24. The wound care was charted as completed on 10/20/24, the day prior to the note above. It was not documented as completed on 10/27/24.

7. On 2/20/25 review of Tenant C1's file revealed the December 2024 MAR reflected an order for

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A 285	Continued From page 13 acetaminophen 500 mg, one tablet two times per day for pain. It was charted as not given due to not being delivered on 12/1/24, 12/2/24, 12/10/24 and 12/17/24. 8. On 2/20/25 review of Tenant C2's file revealed the December 2024 MAR reflected orders for divalproex dr 125 mg capsule sprinkles, two capsules twice per day. It was started on 12/24/24 and discontinued on 1/17/25. It was documented as not administered 10 times between 12/26/24 and 12/31/24. Scheduled Medication Notations indicated it was the wrong medication; it was not available to administer; it could not be located; or was not delivered yet. The MAR also indicated an order for risperidone 0.5 mg, one tablet at bedtime. It was started on 12/24/24 and discontinued on 1/13/25. It was documented as not administered from 12/25/24 to 12/31/24. The Scheduled Medication Notations indicated it was not delivered yet or could not be located. 9. When interviewed on 2/27/25 at 10:20 a.m. the Executive Director said Tenant #1's family brought in her medications even though it had been offered for the Program to obtain them. She said there had been a change to a pharmacy in the Des Moines area. The Program was tracking issues with the pharmacy. She confirmed all MARs and orders were provided.	A 285		
A 325	481-67.9(1) Staffing 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.	A 325		

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A 325	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide a sufficient number of staff available to meet tenant needs. This pertained to 9 of 9 current tenants reviewed (Tenants #1, #2, #3, #4, #5, #6, #7, #8 and #9) and potentially affected all tenants (census of 38). Findings follow: 1. Record review revealed the Adult Services Monitoring Entrance Form indicated there were five staff on first and second shifts and three staff on third shift. The Adult Services Monitoring Entrance Form indicated there were 38 tenants. Continued record review revealed Tenant #4 (current tenant) required the routine assistance of two staff for transfers (see 69.23(1) b for more information related to her level of care. Additionally, two recently discharged tenants (Tenant #2 and Tenant C2) were also identified as exceeding the level of care provided in the Program's policy and procedure (see 67.2(3) for more information related to their level of care). 2. When interviewed on 2/24/25 at 4:29 p.m. Staff C said there were four staff on first and second shift. She said there were a couple of tenants who required full assistance of two to three staff. She said on her shift there were usually four staff. She said tenants did not receive proper hygiene and cares were rushed. When interviewed on 2/25/25 at 10:10 a.m. Staff D said staffing was dependent on the day, sometimes there were five staff and sometimes there were three staff. She said one of the hallways had heavier cares and the medication	A 325		

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passers helped with the cares. She said when staff helped with cares it put the medications behind (in terms of timeliness). She said more than not mediations were not administered on time. She said when Staff J was there to assist she was just there to help with the medication pass. There were also some tenants with behaviors and tenants that required a lot of attention from staff.

When interviewed on 2/25/25 at 10:47 a.m. Staff E said there was typically four staff on her shift. She reported sometimes the medication pass was affected due to cares. She said the medication passer helped out with cares. She said third shift left a mess for first shift (regarding cares).

When interviewed on 2/24/25 at 3:23 p.m. Staff F said they were trying to get four on the floor and on her shift and it had been very short staffed. There was at times there was three staff on the floor. She said staff always strived to complete tasks. There were current and past tenants had required the routine assistance of two people.

When interviewed on 2/25/25 at 4:02 p.m. Staff G said third shift staff were not checking on tenants related to their incontinence. The past weekend, Tenant #9's carpet and bathroom had feces on it, Tenant #4's bed was soaked with urine and Tenant #1's mattress was discolored due to urine when staff arrived on first shift. She said third shift staff were in a rush to leave. She said tenants had been incontinent and the bedding was wet (with urine). It had been mentioned to the Executive Director and to Staff J. She said the lack of toileting cares was negligent. She said staff documented the cares but did not complete them. She said multiple people had

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A 325	Continued From page 16 made complaints. When interviewed on 2/25/25 at 1:32 p.m. the Interim Nurse said all staff had approached her regarding not having enough staff. Staff had reported they could not spend more time with tenants. When interviewed on 2/27/25 at 10:20 a.m. the Executive Director said there was enough staff to meeting the needs of the tenants and there had been no particular complaints. She said shifts were blaming other shifts. She could not confirm issues reported from first shift about third shift but things were being put into place and observations were completed. She confirmed all TARs were provided for the tenants reviewed. 3. Record review on 2/24/25 of Tenant #1's file revealed the December 2024 and January and February 2025 task administration records (TARs) reflected tasks were not completed including for eating, oral cares, incontinence watch, bathing, dressing, personal hygiene and routine safety checks at night. It also reflected tasks not completed at scheduled times, for example safety checks were scheduled at 12:00 a.m., 4:00 a.m. and 10:00 p.m. The 12:00 a.m. for February was documented at 5:16 a.m. on 2/3/25, 10:04 a.m. on 2/9/25, 7:15 a.m. on 2/10/25, 6:41 a.m. on 2/12/25, 6:09 a.m. on 2/17/25 and 6:52 a.m. on 2/19/25. An Incontinence Watch scheduled at 12:00 a.m. was documented at 5:16 a.m. on 2/3/25, 10:04 a.m. on 2/9/25, 7:15 a.m. on 2/10/25, 6:41 a.m. on 2/12/25 and 6:52 a.m. on 2/19/25. These include cares in the timeframe provided in Staff G's interview related to concerns with the provision of cares not being completed	A 325		

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A 325	Continued From page 17 Record review on 2/24/25 of Tenant #2's file revealed the November and December 2024 and January 2025 TARs reflected tasks were not completed including for hearing (partial assist), safety checks twice per night, bathing, dressing, transferring, incontinence management, personal hygiene, oral cares, wheelchair escorts to meals, and safety checks every two hours at night. Record review on 2/24/25 of Tenant #3's file revealed the February 2025 TAR reflected tasks that were not completed including for dressing, eating (assist with prep), oral care and safety checks every two hours at night. Record review on 2/24/25 of Tenant #4's file revealed the February 2025 TAR reflected tasks that were not completed including for medication reminders, bathing, wheelchair escorts to meals and incontinence management. It also reflected tasks not completed at scheduled times, for example safety were scheduled at 12:00 a.m. and 3:00 a.m. The 12:00 a.m. check was documented at 5:16 a.m. on 2/3/25, 10:04 a.m. on 2/9/25, 7:15 a.m. on 2/10/25, 6:42 a.m. on 2/12/25, 6:10 a.m. on 2/17/25 and 6:52 a.m. on 2/19/25. The 3:00 a.m. checks were documented at 5:17 a.m. on 2/3/25, 4:52 a.m. on 2/5/25, 4:36 a.m. on 2/7/25, 6:43 a.m. on 2/8/25, 10:06 a.m. on 2/9/25, 7:15 a.m. on 2/10/25, 4:26 a.m. on 2/11/25, 6:42 a.m. on 2/12/25, 4:53 a.m. on 2/13/25, 6:10 a.m. on 2/17/25, 4:46 a.m. on 2/18/25, 6:53 a.m. on 2/19/25, 4:58 a.m. on 2/20/25, 5:23 a.m. on 2/22/25, 5:37 a.m. on 2/23/25 and 4:40 a.m. on 2/24/25. These include cares in the timeframe and/or shift provided in Staff G's interview related to concerns with the provision of cares not being completed. Record review on 2/24/25 of Tenant #5's file	A 325		

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revealed the December 2024 TAR reflected tasks were not completed including for bathing and safety checks once nightly. The February 2025 TAR reflected tasks were not completed including for safety checks once nightly.

Record review on 2/25/25 of Tenant #6's file revealed the February 2025 TAR reflected tasks were not completed including for bathing, routine safety checks every two hours at night and oral care.

Record review on 2/25/25 of Tenant #7's file revealed the February 2025 TAR reflected tasks were not completed including for oral care, personal hygiene, toileting, dressing and bathing.

Record review on 2/25/25 of Tenant #8's file revealed November and December 2024 and January 2025 TARs reflected tasks were not completed including for nail care, bathing, dressing, oral care, personal hygiene, safety/incontinence checks at night, toileting.

Record review on 2/26/25 of Tenant #9's file revealed January and February 2025 TARs reflected tasks were not completed including for extra housekeeping, dressing, personal hygiene, incontinence check every two hours, toileting, and routine safety checks at night every two hours. It also reflected tasks not completed at scheduled times, for example incontinence checks were scheduled every two hours from 8:00 a.m. to 10:00 p.m. and then at 2:00 a.m. and 5:45 a.m. The 2:00 a.m. check was documented as completed at 6:01 a.m. on 2/1/25, 3:20 a.m. on 2/3/25, 5:17 a.m. on 2/3/25, 4:52 a.m. on 2/5/25, 4:36 a.m. on 2/7/25, 6:43 a.m. on 2/8/25, 10:05 a.m. on 2/9/25, 7:15 a.m. on 2/10/25, 6:42 a.m. on 2/12/25, 3:25 a.m. on 2/14/25, 6:10 a.m. on

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2/17/25, 6:53 a.m. on 2/19/25, 4:42 a.m. on 2/20/25, 4:40 a.m. on 2/24/25, and 6:06 a.m. on 2.26/25. These include cares in the timeframe and/or shift provided in Staff G's interview related to concerns with the provision of cares not being completed.

In summary, the Adult Services Monitoring Entrance Form identified there were 38 tenants, all who had a Global Deterioration Scale of four or greater, which indicated moderate cognitive decline. All 38 tenants received staff assistance with medication administration. There were four tenants receiving hospice services. Five tenants were identified as having wandering behavior and five tenants were identified as tenants who consistently refused cares. Three tenants reviewed, Tenant #2, Tenant #4 and Tenant C2, exceeded the level of care. The tenants either required the routine assistance of at least two staff for transfers and/or had aggressive behaviors. Additionally, staff interviews indicated three other tenants that at times required the assistance of two staff for transfers. One tenant, who was on hospice
and had recently died, one current tenant who had been ill and was sent to the hospital had recently required the assistance of two staff, and some staff indicated at times another current tenant required the assistance of two staff. Six staff interviewed (different shifts) voiced concerns with staffing and cares not being completed. This included one staff who felt the lack of cares completed was negligent and one staff who said medications were often administered late due to not having enough staff. The Interim Nurse confirmed all staff approached her regarding not having enough staff. All nine tenant current tenants reviewed had scheduled tasks not documented as completed. Additionally, incident

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A 325	Continued From page 20 reports, file reviews and staff interviews revealed Tenants #2, #3, #7, #9 and Tenant C2 also had aggressive and/or inappropriate behaviors towards other tenants and/or staff. Review of the schedule revealed the routine use of agency staff. The building had also been without a permanent director of nursing since November of 2024.	A 325		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations within 30 days of taking occupancy. This pertained to 3 of 3 current tenants reviewed (Tenants #1, #3 and #4) and 1 of 1 discharged tenants reviewed (Tenant C1) who were admitted in the past six months. Findings follow: 1. On 2/24/25 review of Tenant #1's file revealed she was admitted on 9/2/24. Tenant #1 did not have evaluations completed within 30 days of taking occupancy. 2. On 2/24/25 review of Tenant #3's file revealed she was admitted on 1/27/25. Tenant #2 did have evaluations completed within 30 days of taking	A 140		

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A 140	Continued From page 21 occupancy. 3. On 2/25/25 review of Tenant #4's file revealed she was admitted on 1/6/25 (however did not move in until 1/26/25). Health and functional evaluations were completed on 1/23/25, 2/7/25 and 2/12/25; however, a cognitive evaluation was not completed at those intervals or within 30 days of taking occupancy. 4. On 2/20/25 review of Tenant C1's file revealed she was admitted on 10/22/24 and discharged on 1/4/25. Health and functional evaluations were completed on 11/25/24 (greater than 30 days after taking occupancy) and a cognitive evaluation was not completed on 11/25/24 or within 30 days of taking occupancy. 5. When interviewed on 2/27/25 at 10:20 a.m. the Executive Director confirmed all evaluations were provided for the tenants reviewed.	A 140		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.	A 145		

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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 6 of 9 current tenants reviewed (Tenant #1, #2, #3, #4, #8 and #9) and 2 of 3 discharged tenants reviewed (Tenants C1, C2). Findings follow:

1. On 2/24/25 review of Tenant #1's file revealed Observations (nurse's notes) indicating the following:
- On 9/3/24 found on the floor. She was assisted up with two staff but was unable to walk and complained of right hip pain. Staff sat her down in a chair and she did not complain of pain. They tried to walk with her again but she was non-weight bearing on the right side.
- On 9/4/24 the former Director of Nursing spoke with family and Tenant #1 was sent out to the ED for evaluation. She had a fracture to her pelvis and femur and would have surgery.
- On 9/10/24 went to a nursing facility for rehabilitation.
- On 9/23/24 returned to the Program. She was weight bearing as tolerated with the assistance of one person with wheeled walker. Tenant #1 was impulsive and ambulated without assistance.
- On 10/1/24 was requiring prompting to consume meals.
- On 12/4/24 spouse was made aware about that incident that occurred last night in the dining room.

A review of incident reports revealed the following:
- On 10/23/24 at 4:00 p.m. a male tenant

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(Tenant C2) had entered Tenant #1's apartment and approached her while she was sitting in her recliner visiting with her family. The male tenant touched her neck, put his hands on her blanket. He made sexual comments. The family member intervened.
- On 12/2/24 staff observed Tenant C2 was groping Tenant #1's thigh and moving his hand toward her genitals in the dining room.

Further review revealed a Therapy Recommendations document dated 10/3/24 indicating Tenant #1's foods should be cut up at meals.

The tenant's most current evaluations provided by the Program were dated 8/26/24. Evaluations were not completed as needed with the return to the program following the nursing facility stay for rehabilitation, and the need for prompting at meals as well as the need for cut up foods.

2. On 2/24/25 review of Tenant #2's file revealed Observations (nurse's notes) indicated the following:
- On 12/17/24 the service plan was updated to reflect Tenant #2 needed the assistance of two staff with transfers, showers and toileting.
- On 12/17/24 yelled at staff while doing cares for him.
- On 12/20/24 wheeled himself over to a female staff and said staff needed to lay on the floor and made a comment about his genitals. He continued to try and get staff to engage in sexual activities.
- On 12/20/24 an incident report was completed related to behavior.
- On 12/23/24 the Interim Nurse indicated she was back in the building, went through observations and spoke with staff. She spoke

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with the Executive Director about Tenant #2's behaviors and the need for this family to be given a 30 day notice.
- On 12/25/24 yelled at staff and kicked the front the door of the office and demanded staff open the door. Staff had been trying to redirect him but it was not working.
- On 12/26/24 did not allow staff to do any cares. He also hit and kicked the doors to the facility.
- On 12/27/24 found "bottomless" in a female tenant's apartment touching her arm. Staff removed him from the apartment.
- On 12/27/24 refused all cares from staff after multiple attempts from different staff. He also refused to eat lunch.
- On 12/28/24 refused all cares from staff. He yelled at staff and threatened to hurt them.
- On 12/29/24 incontinent of bowel and bladder that morning. While trying to change him, he swung his fists at staff and started yelling. It took four staff to clean him up due to him not wanting to stand. He would only stand for 10 seconds before he said to let him down as he could not stand any longer.
- On 1/2/25 refused all cares.
- On 1/4/25 refused all cares from staff.
- On 1/6/25 yelled and screamed at staff as they tried to toilet him that morning.
- On 1/7/25 came out of his apartment without clothing and had a blanket on his lap. Staff told him they were going to take him to his apartment to get him dressed. He "braced his feet to the ground" and called staff names.
- On 1/7/25 the Interim Nurse spoke with the Executive Director about Tenant #2's continued behaviors and the need for a 30 day notice. The Executive Director said she was working on it.
- On 1/9/25 came out of his apartment with just a protective undergarment on. Staff said he needed to go back to his apartment to put on

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clothing. He told staff he was not going to do it. He told staff to lay down on the floor and made a comment about his genitals.
- On 1/24/25 as staff tried to change him he started yelling and hitting staff. It took three staff to change him.
- On 1/28/25 yelled and fought with staff while they took him to the bathroom. It took three staff to complete the task.
- On 1/29/25 it was noted the Executive Director was still working on the 30 day notice for Tenant #2 due to his continued behaviors.
- On 2/1/25 was very aggressive when staff assisted with a shower. He hit, scratched and yelled.
- On 2/10/25 required the assistance of two people for transfers. He was very aggressive, hit and was bit staff.
- On 2/13/25 fighting, biting and was very aggressive.
- On 2/15/25 an incident report was completed regarding tenant to staff behavior.
- On 2/17/25 went out to the hospital due to low oxygen and heart rate and was admitted on 2/18/25 for aspiration pneumonia.
- On 2/20/25 moved to a hospice house and was discharged.

A review of incident reports revealed the following:
- On 12/20/24 staff was trying to assist him with changing and going to the bathroom. He started to get aggressive with staff while they tried to help. Tenant #2 grabbed staff by the shirt and hit staff in the back of the shoulder.
- On 12/26/24 while staff was attempting to assist Tenant #2 with going to the bathroom he got upset and started to scream and hit staff while doing cares.
- On 12/28/24 as staff attempted to help Tenant

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#2 with toileting he became upset and started to hit staff. Another staff walked in and tried to help. He yelled at both staff.
- On 2/15/25 while staff was getting Tenant #2 into his bed he became angry at staff. When staff moved him on the bed, he scratched staff across the face with his nails.

Further record review revealed health and functional evaluations were completed on 11/15/24 for a UTI, 11/20/24 for pneumonia and 12/17/24 for requiring more assistance with transfers. Cognitive evaluations were not completed as needed with these significant changes. Additionally, evaluations were not completed related to Tenant #2's behaviors and decline as noted above.

3. On 2/24/25 review of Tenant #3's file revealed Observations (nurse's notes) indicating the following:
- On 1/31/25 refused medications that morning and three staff had attempted to administer.
- On 2/1/25 very aggressive and pulled staff's hair. She also tried to take staff's jacket off, yelled and tried to hit staff.
- On 2/6/25 very aggressive and liked to hide napkins, forks and spoons in her pants.
- On 2/8/25 walked the halls and said she wanted to go home. Staff approached her with medications, she became upset, started to yell and swung her hands at staff. She started to scream going down the hallway and swung her fists at staff.
- On 2/8/25 very aggressive when staff assisted her to bed.
- On 2/25/25 had someone else's cup and when staff tried to take the cup she threw water on staff.
- On 2/25/25 very aggressive and yelled at staff

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A 145	Continued From page 27 when staff assisted with her shower. The only evaluations provided for Tenant #3 were cognitive evaluations dated 1/17/25 and 1/22/25. Evaluations were not completed as needed with significant change including behaviors as noted above. 4. On 2/25/25 record review revealed the admission date provided was 1/6/25; however, review of Tenant #4' file indicated she did not move in until 1/26/25. Observations (nurse's notes) indicated the following: - On 1/27/25 required the assistance of two staff. She was to receive a shower but she had difficulties completing the task and a sponge bath was given. Tenant #4 was not taking steps and was very hard to lift. - On 1/28/25 required the assistance of two staff with toileting, getting into bed, getting out of the wheelchair. - On 1/29/25 new orders were received to increase APAP to 1000 milligram (mg) every 8 hours PRN (as needed) and add Voltaren Gel 1% to the knees, 4 gm, twice daily PRN, in addition to the scheduled at bedtime. - On 1/31/25 required the assistance of two staff for transfers. Tenant #4 did not move or try to move while being transferred. As staff got her up "her bones started to crack." - On 2/1/25 required the assistance of two staff for transfers. - On 2/6/25 required the assistance of two staff for transfers. - On 2/6/25 when staff assisted Tenant #4 with cares, she was not able to stand all the way up and required the assistance of two staff and a gait belt. She was "completely unable to stand up and bear any of her weight on her own." Tenant #4 said it was too painful and she tried her hardest.	A 145		

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- On 2/6/25 reports were received regarding Tenant #4 needing the assistance of two staff for transfers. Physical therapy (PT) was working on getting PT orders.
- On 2/7/25 said she was scared she was going to fall. Staff was to reassure her of her safety when cares were provided.
- On 2/7/25 required the assistance of three staff for transfers.
- On 2/9/25 required the assistance of two staff for transfers.
- On 2/10/25 required the assistance of three staff for transfers.
- On 2/11/25 required the assistance of two staff for transfers.
- On 2/12/25 would be starting PT for ambulation. Tenant #4's family was aware she was requiring the assistance of two staff for transfers.
- On 2/13/25 required the assistance of two staff for transfers.
- On 2/18/25 required the assistance of two staff for transfers.
- On 2/23/25 required the assistance of two staff on first and second shifts.

Health and functional evaluations were completed on 2/7/25 for adding a pendant and 2/12/25 for PT and requiring the assistance of two people for transfers. Cognitive evaluations were not completed with these significant change evaluations. Additionally, on 2/12/25 the evaluation was completed related to requiring two people for transfers; however, the notes indicated Tenant #4 required the assistance of two people more often than not starting on 1/27/25. Evaluations were not completed when a significant change was observed.

5. On 2/25/25 review of Tenant #8's file revealed

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Observations (nurse's notes) indicating the following:
- On 12/19/24 Tenant #8 and Tenant #9 were observed in the hallway hugging and kissing. Staff redirected the two tenants.
- On 12/27/24 staff observed Tenant #8 and Tenant #9 leave the public restroom.
- On 12/28/24 observed yelling at another tenant in the hallway about her concerns residing at the Program.
- On 12/28/24 asked to go outside several times, said she did not live there and staff needed to let her out. She started to get aggressive.
- On 1/24/25 crying out to due body aches, was very weak and had a thick cough.
- On 1/29/25 the Interim Nurse saw Tenant #8 for her cough and sore on her toe.
- On 1/29/25 left wrist was very swollen.
- On 1/30/25 left wrist had visible swelling, was red and had slight bruising.
- On 1/30/25 a call was placed to the PCP regarding the left arm swelling, pain with movement in the area and had not been feeling well for about a week.
- On 1/30/25 the PCP office called back and ordered labs "stat."
- On 1/30/25 the PCP office called back and the d-dimer was high and she thought it was possible there was a blood clot in her left arm. A prescription for Eliquis was sent.
- On 1/30/25 the Eliquis arrived.
- On 1/30/25 uncomfortable due to left wrist edema.
- On 1/31/25 staff called and said Tenant #8 was much worse and in more pain. She was sent to the ED.

A health and functional evaluation was completed on 1/17/25 (90 day review). Evaluations were not completed with behaviors, a sore toe or changes

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in health status with the respiratory illness or left arm swelling and the start of a blood thinning medication.

6. On 2/26/25 review of Tenant #9's file revealed Observations (nurse's notes) indicating the following:

- On 11/10/24 hit Tenant #8 on the buttocks when she walked by.
- On 12/27/24 came out of the public restroom with Tenant #8.
- On 1/15/25 presented with a significant decline in functional mobility and ambulation. He had impulsive behaviors and reduced safety awareness.
- On 1/16/25 was sent to the ED. He was not able to ambulate or walk on his own. His speech was not clear at times. He had a cough and was clammy.
- On 1/23/25 had not had his bandage on his great toe changed. The nurse on-call provided instructions to staff for the dressing change.
- On 1/30/25 complained of a lot of pain in toe. Staff observed the wound had re-opened due to his sock being "crusted" to it.
- On 1/31/25 hit staff on the buttocks before the bus ride.
- On 2/4/25 required full assistance with dressing.
- On 2/5/25 required full assistance with ambulation to his apartment with a gait belt. He also required full assistance with dressing.
- On 2/7/25 hit staff multiple times.
- On 2/18/25 required full assistance with dressing and toileting.
- On 2/22/25 required full assistance with dressing and toileting.
- On 2/23/25 hit staff on the buttocks and when he was asked to stop, he did it again.

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A 145	Continued From page 31 - On 2/23/25 required full assistance with dressing. Health and functional evaluations were last completed on 1/6/25 (90 day review). Evaluations were not completed related to behaviors, changes in mobility and ambulation, or increased assistance with toileting and dressing. 7. On 2/20/25 of Tenant C1's file revealed Observations (nurse's notes) indicating the following: - On 10/24/24 admitted to hospice upon arrival to the Program yesterday due to a new diagnosis. Hospice discontinued numerous medications and added two orders. - On 11/21/24 staff reported at 3:05 p.m. Tenant C1 had a near choking episode but was able to cough and clear her airway. At 4:30 p.m. staff reported since Tenant C1's family had arrived she now complained of breathing difficulty and had noisy breathing. At that time Tenant C1 reported she felt that something was stuck in her throat. - On 11/25/24 new orders were received from hospice for DuoNeb treatments and scheduled oxycodone. - On 11/26/24 started on oxygen 1 to 4 liters as needed for comfort and shortness of breath. - On 11/26/24 a change of condition was completed due to a decline in Tenant C1's condition. - On 12/14/24 the left side of Tenant C1's buttock was red, open and was bleeding slightly. - On 12/27/24 the Interim Nurse spoke with hospice regarding increased restlessness and agitation as well the sore on her buttocks. - On 12/27/24 the hospice nurse saw Tenant C1 and new orders were received to increase oxycodone, start Haldol, increase prednisone, wound care (coccyx) and start liquid lorazepam	A 145		

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for seizure activity.
- On 12/31/24 staff called due to elevated blood pressure (239/141). The hospice nurse came to assess and her blood pressure was 276/176 and she had a temperature of 100.3. When ambulating she required the assistance of two staff. Her right arm/hand was swollen and her urine was very dark.
- On 12/31/24 wound on her coccyx was more open and red. The Mepilex dressing had blood on it. The lower part of her body and right arm had edema starting at her stomach to her feet. Her upper body was thin.
- On 1/2/25 at 4:45 a.m. staff reported Tenant C1 was struggling to breath and her oxygen saturation was below 90%. Staff was told to administer her PRN medications and notify hospice after medications were given.
- On 1/2/25 at 11:30 a.m. staff reported Tenant C1 was not breathing. The hospice nurse and Interim Nurse were made aware.

Evaluations were completed on 11/25/24 due to shortness of breath and on 10/14/24 for the hospice pre-admission evaluation. Additionally, a health and cognitive evaluation were dated 10/23/24. Evaluations were not completed when hospice services started, with a near choking episode and then with continued decline and a wound, as noted above after the evaluations were completed on 11/26/24.

8. On 2/20/25 review of Tenant C2's Observations (nurse's notes) indicated the following:
- On 10/24/24 the PCP was contacted regarding his sexual behaviors and new orders were received to discontinue escitalopram and start fluoxetine 40 milligram (mg), every day.
- On 10/25/24 family requested Tenant C2 remain on escitalopram at the increased dose of

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20 mg daily, and to discontinue fluoxetine and start duloxetine.
- On 11/4/24 behavior continued despite medication changes and redirections. The "behavior cannot be tolerated in facility." A fax and text message were sent to the PCP.
- On 11/4/24 a new medication had been prescribed by the memory clinic that had been communicated to the Program.
- On 11/4/24 medication change to depakote sprinkles 250 mg, twice daily for behaviors. Family reported Tenant C2 was at a family event recently and he was observed hugging and getting into other's personal space. It was not typical for Tenant C2.
- On 11/19/24 new orders were received for depakote 500 mg every morning and 250 mg every evening.
- On 12/3/24 staff walked down the hall and observed Tenant C2 coming out of Tenant #1's apartment with his pants down and his belt in his hand. Staff asked what he was doing in that apartment and he said "I'm trying to have sex." Tenant C2 also said "I don't know what I am doing." Staff helped him get dressed in his apartment and took him to breakfast.
- On 12/5/24 lab work and urinalysis (UA) returned within normal limits. A new order was received to change divalproex to 500 mg twice daily.
- On 12/11/24 after supper, staff stopped Tenant C2 from going into Tenant #1's apartment. He said for staff to come in with him and have fun. When staff refused to enter his apartment, he tried to grab staff's waist and he insisted they enter his apartment. Staff kept distance and explained it was not respectful to touch people inappropriately. He said he knew but continued to reach out towards staff's breast and his hand was stopped. He was told not to touch staff and said

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he did not care and wanted to go and "have fun." Staff told him to go to his apartment and turn the lights on. He made a comment that he wanted "turn them on" and grabbed his genitals. Tenant C2 went to his apartment after additional attempts to touch staff inappropriately.

- On 12/12/24 chased staff around the dining room and became aggressive when other staff tried to intervene.
- On 12/19/24 the memory care clinic called asking for an update. It was reported Tenant C2 was being treated for a urinary tract infection (UTI) and his last dose of antibiotics was tomorrow. He continued to be resistant to cares and became aggressive with staff.
- On 12/19/24 during a group wellness class Tenant C2 could not keep his hands to himself. He grabbed the wrist of the female tenant next to him and touched her head. He also playfully hit other tenants with the foam noodle. Redirection was attempted several times and he would scowl and continue his behavior.
- On 12/24/24 when staff administered his medications he told staff to give him a kiss. Staff said no and tried to leave the bathroom. Tenant C2 blocked the door with his body, his arms were spread out and tried to grab staff. Staff repeatedly said no and he kept asking why staff did not want to have fun. He raised his fist as if he was going to hit staff and then backed down. He still blocked the bathroom door exit.
- On 12/27/24 tried to kiss staff while administering his medications.
- On 12/27/24 new orders were received to discontinue escitalopram and start fluoxetine.
- On 12/29/24 had low blood pressure, complained of pain in his abdomen, feet and legs. He had a swollen left foot and legs. He had slurred speech and little movement.
- On 12/29/24 family decided to take him to the

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ED for evaluation.
- On 1/18/25 it was noted Tenant C2 died.

A review of incident reports revealed the following:
- On 10/23/24 at 4:00 p.m. Tenant C2 entered Tenant #1's apartment and approached her while she sat in her recliner. He put his hand on her neck and made sexual comments.
- On 11/4/24 while staff was administering medications he came up behind her, grabbed her arms and said "kiss, kiss, kiss." He would not let go.
- On 12/2/24 he was observed by staff groping Tenant #1's thigh and moving his hand toward her genitals. He was redirected to his apartment immediately. Staff would complete hourly checks to ensure he stayed in his apartment.
- On 12/16/24 while staff was cleaning his bathroom, he came up behind her, put both hands on the counter on either side of her and moved his body against hers. She told him to sit down to remove himself from her. He refused but the staff was able to remove herself and reported it.

Review of a fax sent to the tenant's PCP on 11/4/24 indicated Tenant C2's behavior had not changed and had worsened despite medication changes. Tenant C2 followed, groped and made inappropriate comments towards other tenants and staff. The behavior was "predatory, becoming aggressive" and was not within the regulations for assisted living.

Health and functional evaluations were completed with changes in condition 10/8/24, 12/4/24 (post incident with another tenant), 1/1/25 (admission to hospice) and 1/7/25 (additional cares added). Cognitive evaluations were not completed with

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A 145	Continued From page 36 these intervals of significant change. Additionally, evaluations were not completed as needed related when behaviors that were noted above in October and November. 9. Record review on 2/25/25 of Tenant C3's file revealed a health and functional evaluation was completed on 10/31/24 for Tenant C3's admission to hospice. A cognitive evaluation was not completed when the significant change occurred. Continued record review revealed Observations (nurse's notes) indicated the following: -On 11/1/24 it was noted Tenant C3 drank a small amount of water, was repositioned every two hours and had her mouth swabbed. -On 11/4/24 it was noted a hospital bed was ordered for Tenant C3. -On 11/7/24 it was noted new orders were received to discontinue tablet form medications. -On 11/14/24 it was noted Tenant C3 was deceased. Further record review revealed an evaluation was not completed when tablet medications were discontinued, comfort cares were initiated and a hospital bed was ordered. 9. When interviewed on 2/27/25 at 10:20 a.m. the Executive Director confirmed all evaluations were provided for the tenants reviewed.	A 145		

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A 155	481-69.23(1)b Criteria for Admission / 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: b. Requires routine, two-person assistance with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow admission and retention criteria related to two-person transfers. This pertained to 1 of 3 current tenants reviewed admitted in the past six months (Tenant #4). Findings follow: 1. On 2/25/25 record review revealed the admission date provided was 1/6/25; however, review of Tenant #4's file indicated she did not move in until 1/26/25. Observations (nurse's notes) indicated the following: - On 1/27/25 required the assistance of two staff. She was to receive a shower but she had difficulties completing the task and a sponge bath was given. Tenant #4 was not taking steps and was very hard to lift. - On 1/28/25 required the assistance of two staff with toileting, getting into bed, getting out of the wheelchair. - On 1/29/25 new orders were received to increase APAP to 1000 milligram (mg) every 8 hours PRN (as needed) and add Voltaren Gel 1% to the knees, 4 gm, twice daily PRN, in addition to the scheduled at bedtime. - On 1/31/25 required the assistance of two staff for transfers. Tenant #4 did not move or try to	A 155		

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move while being transferred. As staff got her up "her bones started to crack."
- On 2/1/25 required the assistance of two staff for transfers.
- On 2/6/25 required the assistance of two staff for transfers.
- On 2/6/25 when staff assisted Tenant #4 with cares, she was not able to stand all the way up and required the assistance of two staff and a gait belt. She was "completely unable to stand up and bear any of her weight on her own." Tenant #4 said it was too painful and she tried her hardest.
- On 2/6/25 reports were received regarding Tenant #4 needing the assistance of two staff for transfers. Physical therapy (PT) was working on getting PT orders.
- On 2/7/25 said she was scared she was going to fall. Staff was to reassure her of her safety when cares were provided.
- On 2/7/25 required the assistance of three staff for transfers.
- On 2/9/25 required the assistance of two staff for transfers.
- On 2/10/25 required the assistance of three staff for transfers.
- On 2/11/25 required the assistance of two staff for transfers.
- On 2/12/25 would be starting PT for ambulation. Tenant #4's family was aware she was requiring the assistance of two staff for transfers.
- On 2/13/25 required the assistance of two staff for transfers.
- On 2/18/25 required the assistance of two staff for transfers.
- On 2/23/25 required the assistance of two staff on first and second shifts.

2. Review of the first evaluation completed on 1/6/25 (completed prior to admission), revealed

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she transferred independently. The service plan dated 1/6/25 indicated she transferred independently. The second evaluation dated 1/23/25 (prior to move in) indicated she required the assistance of one person for transfers.

The current service plan dated 2/25/25 reflected Tenant #4 was dependent on staff for all transfers and/or required two staff with assist with transfers. The service plan indicated staff would provide a total assist with two staff. A gait belt would be used.

A review of PT treatment notes revealed the following:
- On 2/14/25 better transferring to the toilet than from the toilet. A second person was required for personal cares and clothing management.
- On 2/19/25 required increased time and reassurance during all transfers. Tenant #4 was self-limiting with transfers; she wanted to sit prior to being fully "squared up." The recommendations to Program was an assist of two at that time.
- On 2/24/25 once standing there were multiple attempts to start steps but was only successful in taking one step. She was very limited due to pain today and verbalized that she could not do it. She was agreeable to try after lunch; however, it was the same result as the morning. It was noted "unable to attain standing for further gait training."

3. When interviewed on 2/24/25 at 1:51 p.m. Staff B said Tenant #4 required the assistance of two people for transfer since admission. Tenant #4 did not move her feet well. She felt Tenant #4 needed a higher level of care related to her transfers.

On 2/24/25 at 4:29 p.m. Staff C said Tenant #4

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had required the assistance of two to three staff as soon as she came in. It was her belief Tenant #4 needed a higher level of care.

When interviewed on 2/25/25 at 10:10 a.m. Staff D said at times Tenant #4 required the assistance of two people. She said it occurred about 50% of the time. She thought Tenant #4 had improved since starting PT.

When interviewed on 2/25/25 at 10:47 a.m. Staff E said Tenant #4 required the assistance of two staff but could transfer with one if she was cooperative.

On 2/24/25 at 3:23 p.m. Staff F said Tenant #4 required the assistance of two people every time on her shift. She said Tenant #4 could not stand and had pain related to her arthritis. The gait belt was also painful for Tenant #4.

When interviewed on 2/25/25 at 4:12 p.m. Staff G said Tenant #4 required the assistance of two people for transfers all of the time and sometimes three staff were needed. The tenant did not take steps and she complained about her legs. Staff could at times hear cracking. The tenant had required the assistance of two people for transfers since admission. Staff G had not seen improvement since Tenant #4 started working with PT.

On 2/26/25 at 10:00 a.m. Staff I said Tenant #4 required the assistance of two people everyday.

When interviewed on 2/26/26 at 10:54 a.m. Staff J said Tenant #4 sometimes required the assistance of two people for transfers. She said it might be an issue of retraining for staff and allowing patience for transfers. It was hard for the

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A 155	Continued From page 41 tenant to move her right leg. She did believe though that Tenant #4 needed to be at a higher level of care such as skilled nursing for safer transfers. When interviewed on 2/25/25 at 1:32 p.m. the Interim Nurse said at this time Tenant #4 is a routine two person assist. She required the assistance of two people 50% of the time. She working with PT/OT. She said Tenant #4 was on the radar regarding level of care. At her initial evaluation she was doing everything by herself. Prior to moving in to the program, the tenant had gotten a UTI, gone to the hospital and then to skilled care. At skilled care she ambulated and got out of her chair. When interviewed on 2/27/25 at 10:20 a.m. the Executive Director said PT/OT had seen some improvement. She said Tenant #4 was not at her baseline and was continuing with PT services. They wanted to give her the best opportunity to get to her baseline. When asked about needing a higher level of care she said Tenant #4 had not been given enough time.	A 155		
A 320	481-69.25(1)o Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record)	A 320		

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A 320	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete incident reports as required. This pertained to 6 of 9 current tenants reviewed (Tenant #1, #2, #3, #7, #8 and #9) and 2 of 3 discharged tenants reviewed (Tenants C1, C2). Findings follow: 1. On 2/24/25 review of Tenant #1's file revealed a Program document related to a self-report indicated on 12/3/24 at approximately 6:00 p.m. staff reported Tenant C2 approached Tenant #1 at the dinner table. He put his hand on her thigh and moved it towards her genitals. Staff intervened immediately and he was redirected to his apartment. An incident report was completed for Tenant C2. Continued review revealed an incident report could not be located for Tenant #1 related to the incident documenting what occurred, Tenant #1's response or statement, if there were any injuries and notification of applicable parties (primary care provider and family) 2. On 2/24/25 review of Tenant #2's file revealed Observations (nurse's notes) indicating the following: - On 12/17/24 yelled at staff while doing cares for him. - On 12/25/24 yelled at staff and kicked the front the door of the office and demanded staff open the door. Staff had been trying to redirect him but it was not working. - On 12/29/24 incontinent of bowel and bladder that morning. While trying to change him, he swung his fists at staff and started yelling. It took four staff to clean him up due to him not wanting to stand. He would only stand for 10 seconds	A 320		

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before he said to let him down as he could not stand any longer.
- On 1/6/25 yelled and screamed at staff as they tried to toilet him that morning.
- On 1/7/25 came out of his apartment without clothing and had a blanket on his lap. Staff told him they were going to take him to his apartment to get him dressed. He "braced his feet to the ground" and called staff names.
- On 1/9/25 came out of his apartment with just a protective undergarment on. Staff said he needed to go back to his apartment to put on clothing. He told staff he was not going to do it. He told staff to lay down on the floor and made a comment about his genitals.
- On 1/24/25 as staff tried to change him he started yelling and hitting staff. It took three staff to change him.
- On 1/28/25 yelled and fought with staff while they took him to the bathroom. It took three staff to complete the task.
- On 1/29/25 it was noted the Executive Director was still working on the 30 day notice for Tenant #2 due to his continued behaviors.
- On 2/1/25 was very aggressive when staff assisted with a shower. He hit, scratched and yelled.
- On 2/10/25 required the assistance of two people for transfers. He was very aggressive, hit and was bit staff.
- On 2/13/25 fighting, biting and was very aggressive.

Incident reports could not be located related to the episodes noted above with Tenant #2.

3. On 2/24/25 review of Tenant #3's file revealed Observations (nurse's notes) indicating the following:
- On 2/1/25 very aggressive and pulled staff's

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hair. She also tried to take staff's jacket off, yelled and tried to hit staff.
- On 2/6/25 very aggressive and liked to hide napkins, forks and spoons in her pants.
- On 2/8/25 walked the halls and said she wanted to go home. Staff approached her with medications; she became upset, started to yell and swung her hands at staff. She started to scream going down the hallway and swung her fists at staff.
- On 2/8/25 very aggressive when staff assisted her to bed.

No incident reports could be located related to the events noted above with Tenant #3.

4. On 2/25/25 review of Tenant #7's file revealed Observations (nurse's notes) indicating the following:
- On 1/22/25 refused medications three times that morning. Staff tried three times and she slapped staff's hand at the third attempt and yelled for staff to get away from her.
- On 2/4/25 spit at staff.
- On 2/13/25 very aggressive and also bit staff.
- On 2/23/25 very aggressive while staff assisted her with transferring to the toilet. She tried to bite staff and hit staff.

No incident reports could be located related to the episodes noted above with Tenant #7.

5. On 2/25/25 review of Tenant #8's file revealed Observations (nurse's notes) indicated the following:
- On 12/19/24 was observed in the hallway hugging and kissing Tenant #9. Staff redirected the two tenants.
- On 12/27/24 observed leaving the public restroom with Tenant #9.

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A 320	Continued From page 45 - On 12/28/24 observed yelling at another tenant in the hallway about her concerns residing at the Program. - On 12/28/24 asked to go outside several times; said she did not live there and staff needed to let her out. She started to get aggressive. No incident reports related to the events noted above with Tenant #8 could be located. 6. On 2/26/25 review of Tenant #9's file revealed Observations (nurse's notes) indicating the following: - On 11/10/24 hit Tenant #8 on the buttocks when she walked by. - On 12/27/24 came out of the public restroom with Tenant #8. - On 1/31/25 hit staff on the buttocks before the bus ride. - On 2/7/25 hit staff multiple times. - On 2/23/25 hit staff on the buttocks and when he was asked to stop, he did it again. No incident reports related to the above episodes with Tenant #9 could be located. 7. On 2/20/25 review of Tenant C1's file revealed an Observation (nurse's note) dated 11/21/24 indicated staff reported at 3:05 p.m. Tenant C1 had a near choking episode but was able to cough and clear her airway. At 4:30 p.m. staff reported since family had arrived she now complained of breathing difficulty and had noisy breathing. The tenant reported she felt that something was stuck in her throat. An incident report related to this episode could not be located. 8. On 2/20/25 review of Tenant C2's file revealed	A 320		

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A 320	Continued From page 46 Observations (nurse's notes) indicating the following: - On 12/11/24 after supper, staff stopped Tenant C2 from going into Tenant #1's apartment. He said for staff to come in with him and have fun. When staff refused to enter his apartment, he tried to grab staff's waist and he insisted they enter his apartment. Staff kept their distance and explained it was not respectful to touch people inappropriately. He said he knew but continued to reach out towards staff's breast and his hand was stopped. He was told not to touch staff and said he did not care and wanted to go and "have fun." Staff told him to go to his apartment and turn the lights on. He made a comment that he wanted "turn them on" and grabbed his genitals. Tenant C2 went to his apartment after additional attempts to touch staff inappropriately. - On 12/12/24 chased staff around the dining room and became aggressive when other staff tried to intervene. - On 12/24/24 when staff administered his medications he told staff to give him a kiss. Staff said no and tried to leave the bathroom. Tenant C2 blocked the door with his body, his arms were spread out and tried to grab staff. Staff repeatedly said no and he kept asking why staff did not want to have fun. He raised his fist as if he was going to hit staff and then backed down. He still blocked the bathroom door exit. - On 12/27/24 tried to kiss staff while administering his medications. Incident reports related to the activities listed above could not be located for Tenant C2. 9. Staff interviews revealed the following: - When interviewed on 2/24/25 at 3:32 p.m. Staff F said on 10/26/24 Tenant #5 reported to her she observed Tenant C2 grope Tenant C3	A 320		

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A 320	Continued From page 47 inappropriately in the living room. The former Director of Nursing was called to inform her about what Tenant #5 had reported. Her response was to not document the incident Tenant #5 had reported between Tenant C2 and Tenant C3. Staff F reported there were other occurrences staff were told not to document such as if a tenant had fallen multiple times in a day. - When interviewed on 2/24/25 at 4:29 p.m. Staff C said incident reports were not completed with every fall. - When interviewed on 2/25/25 at 10:10 a.m. Staff D said staff were told not to complete an incident report when a tenant slid to the floor, or a tenant was found on the floor more than a few times in a couple of days. She had heard this from other staff. When interviewed on 2/27/25 at 10:20 a.m. the Executive Director said falls, behaviors and anything out of the ordinary should be documented in incident reports. She confirmed all incident reports were provided for the tenants reviewed.	A 320		
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:	A 360		

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Based on interview and record review the Program failed to update service plans with significant change. This pertained to 8 of 9 current tenants reviewed (Tenant #1, #2, #3, #4, #6, #7, #8 and #9) and 2 of 3 discharged tenants reviewed (Tenants C1, C2). Findings follow:

1. On 2/24/25 review of Tenant #1's file revealed an admission date of 9/2/24. Observations (nurse's notes) indicated the following:
- On 9/3/24 found on the floor. She was assisted up with two staff but was unable to walk and complained of right hip pain. Staff sat her down in a chair and she did not complain of pain. They tried to walk with her again but she was non-weight bearing on the right side.
- On 9/4/24 the former Director of Nursing spoke with family and Tenant #1 was sent out to the ED for evaluation. She had a fracture to her pelvis and femur and would have surgery.
- On 9/10/24 went to a nursing facility for rehabilitation.
- On 9/23/24 returned to the Program. She was weight bearing as tolerated with the assistance of one person with wheeled walker. Tenant #1 was impulsive and ambulated without assistance.
- On 10/1/24 was requiring prompting to consume meals.
- On 12/4/24 spouse was made aware about that incident that occurred last night in the dining room.

A review of incident reports revealed the following:
- On 10/23/24 at 4:00 p.m. a male tenant (Tenant C2) had entered Tenant #1's apartment and approached her while she was sitting in her recliner visiting with her family. The male tenant touched her neck, put his hands on her blanket. He made sexual comments. The family member

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intervened.
- On 12/2/24 staff observed Tenant C2 was groping Tenant #1's thigh and moving his hand toward her genitals in the dining room.

Further review revealed a Therapy Recommendations document dated 10/3/24 indicating Tenant #1's foods should be cut up at meals.

The only signed service plan provided by the Program was signed 9/3/24. The service plan was not updated upon return to the program following the nursing facility stay for rehabilitation or with the need for prompting at meals as well as the need for cut up foods.

2. On 2/24/25 review of Tenant #2's file revealed Observations (nurse's notes) indicated the following:
- On 12/17/24 the service plan was updated to reflect Tenant #2 needed the assistance of two staff with transfers, showers and toileting.
- On 12/17/24 yelled at staff while doing cares for him.
- On 12/20/24 wheeled himself over to a female staff and said staff needed to lay on the floor and made a comment about his genitals. He continued to try and get staff to engage in sexual activities.
- On 12/20/24 an incident report was completed related to behavior.
- On 12/23/24 the Interim Nurse indicated she was back in the building, went through observations and spoke with staff. She spoke with the Executive Director about Tenant #2's behaviors and the need for this family to be given a 30 day notice.
- On 12/25/24 yelled at staff and kicked the front the door of the office and demanded staff open

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the door. Staff had been trying to redirect him but it was not working.
- On 12/26/24 did not allow staff to do any cares. He also hit and kicked the doors to the facility.
- On 12/27/24 found "bottomless" in a female tenant's apartment touching her arm. Staff removed him from the apartment.
- On 12/27/24 refused all cares from staff after multiple attempts from different staff. He also refused to eat lunch.
- On 12/28/24 refused all cares from staff. He yelled at staff and threatened to hurt them.
- On 12/29/24 incontinent of bowel and bladder that morning. While trying to change him, he swung his fists at staff and started yelling. It took four staff to clean him up due to him not wanting to stand. He would only stand for 10 seconds before he said to let him down as he could not stand any longer.
- On 1/2/25 refused all cares.
- On 1/4/25 refused all cares from staff.
- On 1/6/25 yelled and screamed at staff as they tried to toilet him that morning.
- On 1/7/25 came out of his apartment without clothing and had a blanket on his lap. Staff told him they were going to take him to his apartment to get him dressed. He "braced his feet to the ground" and called staff names.
- On 1/7/25 the Interim Nurse spoke with the Executive Director about Tenant #2's continued behaviors and the need for a 30 day notice. The Executive Director said she was working on it.
- On 1/9/25 came out of his apartment with just a protective undergarment on. Staff said he needed to go back to his apartment to put on clothing. He told staff he was not going to do it. He told staff to lay down on the floor and made a comment about his genitals.
- On 1/24/25 as staff tried to change him he started yelling and hitting staff. It took three staff

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to change him.
- On 1/28/25 yelled and fought with staff while they took him to the bathroom. It took three staff to complete the task.
- On 1/29/25 it was noted the Executive Director was still working on the 30 day notice for Tenant #2 due to his continued behaviors.
- On 2/1/25 was very aggressive when staff assisted with a shower. He hit, scratched and yelled.
- On 2/10/25 required the assistance of two people for transfers. He was very aggressive, hit and was bit staff.
- On 2/13/25 fighting, biting and was very aggressive.
- On 2/15/25 an incident report was completed regarding tenant to staff behavior.
- On 2/17/25 went out to the hospital due to low oxygen and heart rate and was admitted on 2/18/25 for aspiration pneumonia.
- On 2/20/25 moved to a hospice house and was discharged.

A review of incident reports revealed the following:
- On 12/20/24 staff was trying to assist him with changing and going to the bathroom. He started to get aggressive with staff while they tried to help. Tenant #2 grabbed staff by the shirt and hit staff in the back of the shoulder.
- On 12/26/24 while staff was attempting to assist Tenant #2 with going to the bathroom he got upset and started to scream and hit staff while doing cares.
- On 12/28/24 as staff attempted to help Tenant #2 with toileting he became upset and started to hit staff. Another staff walked in and tried to help. He yelled at both staff.
- On 2/15/25 while staff was getting Tenant #2 into his bed he became angry at staff. When staff

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moved him on the bed, he scratched staff across the face with his nails.

Further record review revealed health and functional evaluations were completed on 11/15/24 for a UTI, 11/20/24 for pneumonia and 12/17/24 for requiring more assistance with transfers.

There were no signed, updated service plans located at these intervals of significant change.

3. On 2/24/25 review of Tenant #3's file revealed Observations (nurse's notes) indicating the following:
- On 1/31/25 refused medications that morning and three staff had attempted to administer.
- On 2/1/25 very aggressive and pulled staff's hair. She also tried to take staff's jacket off, yelled and tried to hit staff.
- On 2/6/25 very aggressive and liked to hide napkins, forks and spoons in her pants.
- On 2/8/25 walked the halls and said she wanted to go home. Staff approached her with medications, she became upset, started to yell and swung her hands at staff. She started to scream going down the hallway and swung her fists at staff.
- On 2/8/25 very aggressive when staff assisted her to bed.
- On 2/25/25 had someone else's cup and when staff tried to take the cup she threw water on staff.
- On 2/25/25 very aggressive and yelled at staff when staff assisted with her shower.

Tenant #3's service plan was dated 1/22/25. The service plan did not reflect these behaviors or any interventions related to the behaviors.

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4. On 2/25/25 record review revealed the admission date provided was 1/6/25; however, review of Tenant #4' file indicated she did not move in until 1/26/25. Observations (nurse's notes) indicated the following:
- On 1/27/25 required the assistance of two staff. She was to receive a shower but she had difficulties completing the task and a sponge bath was given. Tenant #4 was not taking steps and was very hard to lift.
- On 1/28/25 required the assistance of two staff with toileting, getting into bed, getting out of the wheelchair.
- On 1/29/25 new orders were received to increase APAP to 1000 milligram (mg) every 8 hours PRN (as needed) and add Voltaren Gel 1% to the knees, 4 gm, twice daily PRN, in addition to the scheduled at bedtime.
- On 1/31/25 required the assistance of two staff for transfers. Tenant #4 did not move or try to move while being transferred. As staff got her up "her bones started to crack."
- On 2/1/25 required the assistance of two staff for transfers.
- On 2/6/25 required the assistance of two staff for transfers.
- On 2/6/25 when staff assisted Tenant #4 with cares, she was not able to stand all the way up and required the assistance of two staff and a gait belt. She was "completely unable to stand up and bear any of her weight on her own." Tenant #4 said it was too painful and she tried her hardest.
- On 2/6/25 reports were received regarding Tenant #4 needing the assistance of two staff for transfers. Physical therapy (PT) was working on getting PT orders.
- On 2/7/25 said she was scared she was going to fall. Staff was to reassure her of her safety when cares were provided.
- On 2/7/25 required the assistance of three staff

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for transfers.
- On 2/9/25 required the assistance of two staff for transfers.
- On 2/10/25 required the assistance of three staff for transfers.
- On 2/11/25 required the assistance of two staff for transfers.
- On 2/12/25 will be starting PT for ambulation. Tenant #4's family was aware she was requiring the assistance of two staff for transfers.
- On 2/13/25 required the assistance of two staff for transfers.
- On 2/18/25 required the assistance of two staff for transfers.
- On 2/23/25 required the assistance of two staff on first and second shifts.

Health and functional evaluations were completed on 2/7/25 for adding a pendant and 2/12/25 for PT and requiring the assistance of two people for transfers.

There were no signed service plan updates at these intervals of significant change. The current unsigned service plan dated 2/27/25 (date requested) reflected she was dependent on staff for transfers and/or required two people to assist with transfers.

5. On 2/24/25 review of Tenant #6's file revealed Observations (nurse's notes) indicating the following:
- On 1/2/25 had a fall at family's home and was taken to the ED. She was admitted to the hospital with a C5 fracture (neck fracture) and pulmonary embolus. She was in a Miami J Collar.
- On 1/6/25 was on her way back from the hospital. Her neck brace was to be worn at all times so her head was straight.
- On 1/7/25 walking around without her neck

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brace on. Staff put it back on her and reminded her to wear it at all times.
- On 1/8/25 staff completed rounds on third shift and observed Tenant #6 without her neck brace on.

Tenant #6's service plan with an effective date of 2/24/25 (date requested) reflected the Miami J Collar cleaning of her collar pads; however, did not reflect she removed the brace and needed reminders to keep the brace on.

6. On 2/25/25 review of Tenant #7's file revealed Observations (nurse's notes) indicated the following:
- On 1/22/25 refused medications three times that morning. Staff tried three times and she slapped staff's hand at the third attempt and yelled for staff to get away from her.
- On 2/4/25 spit at staff today.
- On 2/13/25 very aggressive and also biting staff.
- On 2/23/25 very aggressive while staff assisted her with transferring to the toilet. She tried to bite and hit staff.

No signed service plans were provided for Tenant #7. An unsigned service plan with an effective date of 2/25/25 (date requested) was provided. The service plan provided did not reflect Tenant #7's behavior as noted above.

7. On 2/25/25 review of Tenant #8's file revealed Observations (nurse's notes) indicating the following:
- On 12/19/24 Tenant #8 and Tenant #9 were observed in the hallway hugging and kissing. Staff redirected the two tenants.
- On 12/27/24 staff observed Tenant #8 and Tenant #9 leave the public restroom.

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A 360	Continued From page 56 - On 12/28/24 observed yelling at another tenant in the hallway about her concerns residing at the Program. - On 12/28/24 asked to go outside several times, said she did not live there and staff needed to let her out. She started to get aggressive. - On 1/24/25 crying out to due body aches, was very weak and had a thick cough. - On 1/29/25 the Interim Nurse saw Tenant #8 for her cough and sore on her toe. - On 1/29/25 left wrist was very swollen. - On 1/30/25 left wrist had visible swelling, was red and had slight bruising. - On 1/30/25 a call was placed to the PCP regarding the left arm swelling, pain with movement in the area and had not been feeling well for about a week. - On 1/30/25 the PCP office called back and ordered labs "stat." - On 1/30/25 the PCP office called back and the d-dimer was high and she thought it was possible there was a blood clot in her left arm. A prescription for Eliquis was sent. - On 1/30/25 the Eliquis arrived. - On 1/30/25 uncomfortable due to left wrist edema. - On 1/31/25 staff called and said Tenant #8 was much worse and in more pain. She was sent to the ED. - On 2/5/25 it was noted she went to skilled care for therapy. A signed service plan was not provided for Tenant #8. An unsigned service plan with the effective date of 2/25/25 (date requested) was provided. A signed service plan was not developed related to behaviors, a sore toe or changes in health status with the respiratory illness or left arm swelling and the start of a blood thinning medication.	A 360		

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A 360	Continued From page 57 8. On 2/26/25 review of Tenant #9's file revealed Observations (nurse's notes) indicating the following: - On 11/10/24 hit Tenant #8 on the buttocks when she walked by. - On 12/27/24 came out of the public restroom with Tenant #8. - On 1/15/25 presented with a significant decline in functional mobility and ambulation. He had impulsive behaviors and reduced safety awareness. - On 1/16/25 was sent to the ED. He was not able to ambulate or walk on his own. His speech was not clear at times. He had a cough and was clammy. - On 1/23/25 had not had his bandage on his great toe changed. The nurse on-call provided instructions to staff for the dressing change. - On 1/30/25 complained of a lot of pain in toe. Staff observed the wound had re-opened due to his sock being "crusted" to it. - On 1/31/25 hit staff on the buttocks before the bus ride. - On 2/4/25 required full assistance with dressing. - On 2/5/25 required full assistance with ambulation to his apartment with a gait belt. He also required full assistance with dressing. - On 2/7/25 hit staff multiple times. - On 2/18/25 required full assistance with dressing and toileting. - On 2/22/25 required full assistance with dressing and toileting. - On 2/23/25 hit staff on the buttocks and when he was asked to stop, he did it again. - On 2/23/25 required full assistance with dressing. A signed service plan was not provided for Tenant #9. A current unsigned service plan with an	A 360		

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effective date of 2/27/25 (date requested) was provided. The service plan was not signed and updated related to behaviors, changes in mobility and ambulation, pain and increased assistance with toileting and dressing.

9. On 2/20/25 of Tenant C1's file revealed Observations (nurse's notes) indicating the following:
- On 10/24/24 admitted to hospice upon arrival to the Program yesterday due to a new diagnosis. Hospice discontinued numerous medications and added two orders.
- On 11/21/24 staff reported at 3:05 p.m. Tenant C1 had a near choking episode but was able to cough and clear her airway. At 4:30 p.m. staff reported since Tenant C1's family had arrived she now complained of breathing difficulty and had noisy breathing. At that time Tenant C1 reported she felt that something was stuck in her throat.
- On 11/25/24 new orders were received from hospice for DuoNeb treatments and scheduled oxycodone.
- On 11/26/24 started on oxygen 1 to 4 liters as needed for comfort and shortness of breath.
- On 11/26/24 a change of condition was completed due to a decline in Tenant C1's condition.
- On 12/14/24 the left side of Tenant C1's buttock was red, open and was bleeding slightly.
- On 12/27/24 the Interim Nurse spoke with hospice regarding increased restlessness and agitation as well the sore on her buttocks.
- On 12/27/24 the hospice nurse saw Tenant C1 and new orders were received to increase oxycodone, start Haldol, increase prednisone, wound care (coccyx) and start liquid lorazepam for seizure activity.
- On 12/31/24 staff called due to elevated blood pressure (239/141). The hospice nurse came to

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assess and her blood pressure was 276/176 and she had a temperature of 100.3. When ambulating she required the assistance of two staff. Her right arm/hand was swollen and her urine was very dark.
- On 12/31/24 wound on her coccyx was more open and red. The Mepilex dressing had blood on it. The lower part of her body and right arm had edema starting at her stomach to her feet. Her upper body was thin.
- On 1/2/25 at 4:45 a.m. staff reported Tenant C1 was struggling to breath and her oxygen saturation was below 90%. Staff was told to administer her PRN medications and notify hospice after medications were given.
- On 1/2/25 at 11:30 a.m. staff reported Tenant C1 was not breathing. The hospice nurse and Interim Nurse were made aware.

A signed service plan was provided dated 10/23/24. The service plan was not updated when hospice services started, with a near choking episode and then with continued decline as noted above.

10. On 2/20/25 review of Tenant C2's Observations (nurse's notes) indicated the following:
- On 10/24/24 the PCP was contacted regarding his sexual behaviors and new orders were received to discontinue escitalopram and start fluoxetine 40 milligram (mg), every day.
- On 10/25/24 family requested Tenant C2 remain on escitalopram at the increased dose of 20 mg daily, and to discontinue fluoxetine and start duloxetine.
- On 11/4/24 behavior continued despite medication changes and redirections. The "behavior cannot be tolerated in facility." A fax and text message were sent to the PCP.

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- On 11/4/24 a new medication had been prescribed by the memory clinic that had been communicated to the Program.
- On 11/4/24 medication change to depakote sprinkles 250 mg, twice daily for behaviors. Family reported Tenant C2 was at a family event recently and he was observed hugging and getting into other's personal space. It was not typical for Tenant C2.
- On 11/19/24 new orders were received for depakote 500 mg every morning and 250 mg every evening.
- On 12/3/24 staff walked down the hall and observed Tenant C2 coming out of Tenant #1's apartment with his pants down and his belt in his hand. Staff asked what he was doing in that apartment and he said "I'm trying to have sex." Tenant C2 also said "I don't know what I am doing." Staff helped him get dressed in his apartment and took him to breakfast.
- On 12/5/24 lab work and urinalysis (UA) returned within normal limits. A new order was received to change divalproex to 500 mg twice daily.
- On 12/11/24 after supper, staff stopped Tenant C2 from going into Tenant #1's apartment. He said for staff to come in with him and have fun. When staff refused to enter his apartment, he tried to grab staff's waist and he insisted they enter his apartment. Staff kept distance and explained it was not respectful to touch people inappropriately. He said he knew but continued to reach out towards staff's breast and his hand was stopped. He was told not to touch staff and said he did not care and wanted to go and "have fun." Staff told him to go to his apartment and turn the lights on. He made a comment that he wanted "turn them on" and grabbed his genitals. Tenant C2 went to his apartment after additional attempts to touch staff inappropriately.

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(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 360	Continued From page 61 - On 12/12/24 chased staff around the dining room and became aggressive when other staff tried to intervene. - On 12/19/24 the memory care clinic called asking for an update. It was reported Tenant C2 was being treated for a urinary tract infection (UTI) and his last dose of antibiotics was tomorrow. He continued to be resistant to cares and became aggressive with staff. - On 12/19/24 during a group wellness class Tenant C2 could not keep his hands to himself. He grabbed the wrist of the female tenant next to him and touched her head. He also playfully hit other tenants with the foam noodle. Redirection was attempted several times and he would scowl and continue his behavior. - On 12/24/24 when staff administered his medications he told staff to give him a kiss. Staff said no and tried to leave the bathroom. Tenant C2 blocked the door with his body, his arms were spread out and tried to grab staff. Staff repeatedly said no and he kept asking why staff did not want to have fun. He raised his fist as if he was going to hit staff and then backed down. He still blocked the bathroom door exit. - On 12/27/24 tried to kiss staff while administering his medications. - On 12/27/24 new orders were received to discontinue escitalopram and start fluoxetine. - On 12/29/24 had low blood pressure, complained of pain in his abdomen, feet and legs. He had a swollen left foot and legs. He had slurred speech and little movement. - On 12/29/24 family decided to take him to the ED for evaluation. - On 1/18/25 it was noted Tenant C2 died. A review of incident reports revealed the following: - On 10/23/24 at 4:00 p.m. Tenant C2 entered	A 360		

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	16427_hfd	A. BUILDING: _____ B. WING _____	C 02/27/2025

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A 360	Continued From page 62	A 360		

Tenant #1's apartment and approached her while she sat in her recliner. He put his hand on her neck and made sexual comments.
- On 11/4/24 while staff was administering medications he came up behind her, grabbed her arms and said "kiss, kiss, kiss." He would not let go.
- On 12/2/24 he was observed by staff groping Tenant #1's thigh and moving his hand toward her genitals. He was redirected to his apartment immediately. Staff would complete hourly checks to ensure he stayed in his apartment.
- On 12/16/24 while staff was cleaning his bathroom, he came up behind her, put both hands on the counter on either side of her and moved his body against hers. She told him to sit down to remove himself from her. He refused but the staff was able to remove herself and reported it.

Review of a fax sent to the tenant's PCP on 11/4/24 indicated Tenant C2's behavior had not changed and had worsened despite medication changes. Tenant C2 followed, groped and made inappropriate comments towards other tenants and staff. The behavior was "predatory, becoming aggressive" and was not within the regulations for assisted living.

Continued record review revealed the most recent signed service plan provided by the Program was dated 8/23/24. Health and functional evaluations were completed with changes in condition 10/8/24 (change of condition), 12/4/24 (post incident with another tenant), 1/1/25 (admission to hospice) and 1/7/25 (additional cares added). The service plan was not updated with each of those significant change intervals. An unsigned service plan was provided with an effective date of 2/20/25 (date requested).

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A 360	Continued From page 63 The service plan reflected hospice; however, did not reflect Tenant C2's behaviors and interventions. 11. When interviewed on 2/27/25 at 10:20 a.m. the Executive Director confirmed all service plans were provided for the tenants reviewed.	A 360		
A 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse reviews as needed. This pertained to 5 of 9 current tenants reviewed (Tenant #1, #2, #3, #5 and #9) and 1 of 1 discharged tenants reviewed who reported a sexual incident (Tenant C1). Findings follow: 1. On 2/24/25 review of Tenant #1's file revealed an Observation (nurse's note) indicated the following: - On 2/3/25 was seen in the emergency department (ED) on 1/31/25. Tenant #1 was positive for Influenza A and the x-ray was	A 430		

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A 430	Continued From page 64 negative for pneumonia. An After Visit Summary (AVS) dated 1/31/25 indicated Tenant #1 was seen for Influenza A and dehydration. Orders were received to take Tamiflu 1 capsule 75mg (milligrams) twice daily for 5 days, and Tylenol 650 mg, four times per day for the next three days and then as needed. A nurse review to follow up after Tenant #1 was positive for Influenza A, was prescribed treatment, and to determine if Tenant #1 had any further signs or symptoms of respiratory illness could not be located. Further record review revealed a 90 day nurse review was last completed on 10/21/24 in nurse's notes. A nurse review had not been completed in the past 90 days. 2. On 2/24/25 review of Tenant #2's file revealed Observations (nurse's notes) indicating the following: - On 11/13/24 new orders were received including for urinanalysis (UA) with culture and sensitivity. - On 11/14/24 UA results were received and indicated a urinary tract infection (UTI). The results were forwarded to the primary care provider (PCP). It was noted as potentially an explanation for the new onset of sexually inappropriate behavior towards staff. - On 11/15/24 new orders were received to start levofloxacin 250 mg, for five days for treatment of the UTI. A nurse review to follow up after Tenant #2 had a UTI and prescribed treatment, and to determine if Tenant #2 had any further signs and symptoms of a UTI could not be located.	A 430		

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A 430	Continued From page 65 3. On 2/24/25 review of Tenant #3's file revealed Observations (nurse's notes) indicated the following: - On 2/20/25 had a cough and sounded congested. - On 2/21/25 refused breakfast, had a runny nose and cough. Tenant #3 complained of body aches and she had trouble standing. - On 2/25/25 a fax was sent to PCP regarding her cough, runny nose, body aches and that she had been sleeping. - On 2/25/25 observed at breakfast today. No coughing or runny nose was noted. She walked the halls after breakfast. A fax sent to the tenant's PCP on 2/22/25 indicated Tenant #3 had a cough, runny nose, body aches and did not eat breakfast. She had been laying in bed. The PCP indicated to monitor, call with changes in vital signs or worsening condition. Further record review revealed vital signs for Tenant #3 were requested for February 2025. The only recorded vital signs were on 2/6/25. Vitals signs not were taken with signs of respiratory illness or when directed by the PCP to monitor, including vitals signs. A nurse review that included vital signs and continued monitoring from the onset of the illness on 2/20/25 until it resolved on 2/25/25 could be located. 4. On 2/25/25 review of Tenant #5's file revealed Observations (nurse's notes) indicated the following: - On 1/27/25 staff reported Tenant #5 had blood in her urine and hip pain. Family was taking	A 430		

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A 430	Continued From page 66	A 430		

Tenant #5 to the ED.
- On 1/27/25 back from the ED and diagnosed with a bladder infection. An antibiotic was given in the ED and would be sent to the pharmacy.
- On 1/29/25 new orders were received on 1/28/25 including to continue current Keflex 500 mg, four times per day for five days. Hematuria was noted last night but not today.

A nurse review to follow up after Tenant #5 had a bladder infection and prescribed treatment, to determine if Tenant #2 had any further signs and symptoms of a bladder infection could be located.

Additionally, a 90 day review had not completed in the past 90 days.

5. On 2/26/25 review of Tenant #9's file revealed Observations (nurse's notes) indicating the following:
- On 1/16/25 was sent to ED. He was not able to walk on his own, speech was not clear at times, he had a cough and was clammy. (There was no follow up note completed with his return and regarding any new orders).
- On 1/23/25 did not have bandage on his great toe changed. The nurse on-call was notified and staff was told to cleanse thoroughly with soap and water, bandage wound with gauze and Vaseline.
- On 1/30/25 complained of a lot of pain in the toe. Staff observed wound on toe and it had re-opened due to the sock being "crusted to it." Staff notified the nurse and were instructed to cleanse, apply triple antibiotic ointment, gauze and roll gauze.
- On 1/30/25 the Interim Nurse said she received a call from staff regarding Tenant #9's great toe and a skin tear. There was no signs/symptoms at that time. Staff J would follow up in the morning (Staff J was not a licensed

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A 430	Continued From page 67	A 430		

staff).
- On 2/8/25 when staff were assisting Tenant #9 to clean his genitals during cares staff felt a an object in the center of his scrotum. The supervisor was notified.
- On 2/22/25 had a painful knot on the right side of his forehead.

A nurse reviews could not be located related to Tenant #9's ED visit on 1/16/25 including his return and if any new orders were received. Additionally nurse reviews were not located related to the toe wound (pain and treatment), the object noted by staff in Tenant #9's scrotum and the painful area on the right side of his forehead.

6. On 2/20/25 review of Tenant C1's file revealed an incident report dated 10/26/24 indicating Tenant C1 had told her family she had been sexually assaulted the previous night. At 1:00 p.m. Tenant C1 reported to family that she had been sexually assaulted provided a description of a man. She said a man climbed in her bed, groped her and insisted she enjoyed the sexual act.

Continued record review revealed a nurse review could not be located or any assessment for any possible injuries related to the incident noted above for Tenant C1.

7. When interviewed on 2/27/25 at 10:20 a.m. the Executive Director confirmed all nurse reviews were provided for the tenants reviewed.

CountryHouse Residence

Cedar Rapids

Plan of Correction Date: 3.20.25

A 150

481-67 .2(3) Program and Policies and Procedures

Program failed to follow its policy and procedure related to admission and retention criteria.

CountryHouse Residents policy for admission denial, retention or discharge include but are not limited to, the need for skilled monitoring, testing and aggressive adjustment of medications and treatment where there is the presence of or risk for a fluctuating acute condition, monitoring of chronic medical conditions that are not controllable through readily available medications and treatments.

Not be admitted, readmitted, or retained if he or she requires complex nursing interventions or has conditions which are not stable or predictable unless his or her designee assumes responsibility for arranging for the Resident's care through a licensed outside healthcare provider.

The Director of Nursing, Executive Director and Wellness Assistant will review each significant change to ensure qualifications are met to remain in assisted living.

Weekly Wellness meetings will occur to review each resident's status and if all needs have been met.

The program will track these weekly meetings for the next 6 months and if compliant, the meetings will be reduced to twice a month for the next 3 months with a goal of monthly if compliant.

A 285

481.67.5 (2) f (4) Medications

Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner and physician assistant.

Every Wednesday the cart will be inventoried to look at medication supplies of any multidose vials (i.e. Miralax, eye drops, insulins, creams/powders, etc) and PRN medications to ensure there is an adequate supply to last through the weekend. (During this inventory expiration dates of all multidose vials and PRN medications should be noted and a new supply ordered if expired). If medications are needed prior to the end

of the weekend they should be ordered from the pharmacy. This task should be assigned to a specific Med Aid who will be responsible for ensuring this task is completed. Please note if there is a holiday during the weekend or the following Monday, the pharmacy may be closed for an extended time to observe the holiday, and it may require a greater supply on hand.

If any Med Aid notices a medication supply is getting low, it should be reordered to avoid running out. Best Practices indicates when a multidose vial of medication has a reserve of 5 days or less it should be reordered.

All new orders that have been ordered by a Physician “after hours and on weekends or holidays” will be followed up on the next day by the Director of Nursing, Wellness Assistant or Executive Director.

Medication aides received training on “avoiding Medications Unavailable” and the Director of Nursing runs a report on dashboard called “no pass medication” daily. If a community falls under 90% compliance the DON will provide daily report to the Regional Nurse of missed medications. The regional nurse will track missed medications, assist with proactive measures to prevent further missed medications.

A 325

481.67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants’ identified needs.

Based on our current census and acuity we will staff as follows:

1st Shift will 4 trained staff members at all times, with an alternate from 7 – 1 p.m.

2nd Shift will have 4 trained staff members at all times, with an alternate from 4 – 8 p.m.

3rd Shift will have 3 trained staff members at all times.

This will be monitored by the staffing program Onshift weekly by Director of Nursing.

A 140

481-69.22(2) Evaluation of Tenant

69.22(2) Evaluation within 30 days of occupancy.

Each tenant will be evaluated for functional, cognitive and health status within 30 days of occupancy.

Since November 13th several RN’s have filled in at the community until hiring a full-time RN including agency nurses. The new Director of Nursing has been hired and will be trained on rule 69.22(2) Evaluations 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 significate change.

Monthly audits will occur by the Executive Director and will be performed to ensure each step of the functional, cognitive and health status was performed per regulations for a period of one year.

A 145

481-69(3) Evaluation of Tenant

69.22(3) evaluation annually and with significant change.

Each tenant will be evaluated for functional, cognitive and health status annually or with a significant change.

Since November 13th several RN's have filled in at the community until hiring a full-time RN including agency nurses. The new Director of Nursing has been hired and will be trained on rule 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. 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 significate change.

Monthly audits will occur by the Executive Director will be performed to ensure each step of the functional, cognitive and health status was performed per regulations for a period of one year.

A155

481.69.23(1)b Criteria for Admission/Retention of Tenants

69.23(1) Person who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who:

b. Requires two-person assistance with standing, transfer or evacuation.

The program will monitor all resident changes and if determined a resident is a two-person assist more then 50% of the time after PT/OT services a 30-day notice will be given.

The Director of Nursing will monitor, and advice advise Executive Director of need for 30 day notice for anyone in need of the notice who exceeds this requirement.

A 320 481-69.25(1)o Tenant Documents

69.25(1) Documentation for each tenant shall be maintained by the program and shall include:

o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements.

Since November 13th several RN's have filled in at the community until hiring a full-time RN including agency nurses. The new Director of Nursing has been hired and will be trained on rules and regulations for Assisted Living in the state of Iowa and policies and procedures from Agemark.

Settling have been added to our electronic health record system ECP to inform the Executive Director and the Director of Nursing by email when an Incident report has been filed. All direct care staff are participating in a mandatory training on incident reports. Training began on February 20th and will be ongoing.

Documentation review will be performed by Director of Nursing at the community monthly and the VP of Nursing at Agemark quarterly.

A 360 481-69.26(3) Service Plans

69.29(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 wit significant change, but not less than annually.

Since November 13th several RN's have filled in at the community until hiring a full-time RN including agency nurses. The new Director of Nursing has been hired and will be trained on rules and regulations for Assisted Living in the state of Iowa and policies and procedures from Agemark.

Documentation review will be performed by Director of Nursing at the community monthly and the VP of Nursing at Agemark quarterly.

A 430 481-69.27(1)c Nurse review

69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted by a registered nurse.

Since November 13th several RN's have filled in at the community until hiring a full-time RN including agency nurses. The new Director of Nursing has been hired and will be trained on rules and regulations for Assisted Living in the state of Iowa and policies and procedures from Agemark. Nurse reviews will be performed every 90 days or as needed with significant change.

Documentation review will be performed by Director of Nursing at the community monthly and the VP of Nursing at Agemark quarterly.

√ 4/29/25