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
	S0463	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARSTONE SENIOR LIVING	4715 ALGONQUIN DRIVE CEDAR FALLS, IA 50613

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A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 59 Number of tenants with cognitive impairment: 3 Total census: 62 The following regulatory insufficiencies were cited related to the investigation of Incidents #128992-I, #129591-I and #130033-I:	A 000	See attached POC 10/10/25	
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide adequate and appropriate services and cares for 2 of 2 current tenants reviewed (Tenant #1 and Tenant #2). Findings followed: 1. Record review of an internal document indicated on 5/27/25 Staff B reported to the	A 160		

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

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A 160	Continued From page 1 Executive Director during the morning shift she found Tenant #1 was soiled through her clothing. It was determined the evening staff, Staff A, assisted Tenant #1 with dressing for bed and did not reattach her emergency pendant. Tenant #1 requested to stay in her recliner as she was not ready for bed. Staff A said she would return to assist Tenant #1 later but did not do it and she was not able to call for assistance during the night. The document indicated an internal review confirmed Staff A did not put the pendant back on her. The internal investigation did not find any "malicious intent." Staff A was not feeling well and appeared to be distracted on her shift. Continued record review on 7/21/25 of Tenant #1's file revealed Tenant #1 had a diagnosis of Parkinson's disease. The service plan reflected Tenant #1 would receive assistance with transferring and mobility. The service plan indicated she would receive escort assistance. It also indicated she was independent in the use of the call and safety system. It indicated she woke up without prompting. She used her pendant to notify staff when she was ready to start her Further record review revealed a skin assessment in Progress Notes indicated on 5/26/25 a head to toe skin check was completed. There was redness/breakdown observed on her buttocks. The notes indicated the area was not open but it appeared to be breaking down and was red. The location of the wound was on her coccyx. Continued record review of pendant history records for Tenant #1 indicated a pendant call was made on 5/25/25 at 8:38 p.m. and was responded to by Staff A. The next pendant call	A 160		

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was on 5/26/25 at 11:31 a.m. and responded to by Staff B.

An attempt was made to interview Staff A; however, was not successful. Staff A provided a statement to the Program dated 5/27/25. Her statement indicated she worked on 5/25/25 at 7:00 p.m. She assisted Tenant #1 after she used her pendant and requested to get dressed for bed, but wanted to sit in her recliner and watch television. Staff A assisted Tenant #1 with toileting and changed her brief and clothing while she as on the toilet. She put her pajamas on her and put her shoes back on. She hung Tenant #1's pendant up to the side so it would not get in the way of removing or applying clothing. After toileting she assisted her to the sink and Tenant #1 brushed her teeth. Staff A removed garbage from Tenant #1's apartment and when she returned Tenant #1 said maybe she should go to bed so Staff A did not have to come back up. Staff A told her it was fine if she wanted to stay up and not a problem to come back when she was ready. Staff A noted Tenant #1 felt sympathetic for her because she was sick and wearing a mask. Tenant #1 thanked her for her assistance and they walked to the recliner. Staff A ensured she was seated safely. She reminded Tenant #1 to let her know when she was ready. Staff A left the apartment and not long after called the Wellness Director and asked to leave work early due to illness. It was approved and she left for the night.

When interviewed on 7/21/25 at 2:14 p.m. Staff B said she went in to assist Tenant #1 getting ready for the day. Tenant #1 said she had been in her recliner all night. She said the person had gone in and had her ready for bed, put her in her

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recliner and did not come back. As time went on she realized she did not have her pendant and it was left in the bathroom. Tenant #1 sat in her recliner all night. Staff B said Tenant #1 normally slept in her bed at night. She would normally go in and check on Tenant #1 at 9 or 9:30 a.m. if she had not called for assistance. Staff B said Tenant #`1 was in night clothes and Staff B observed her pendant in the bathroom hanging up on the toilet paper roll. Tenant #1 was incontinent of bladder, but noted it was normal for her to be incontinent. It appeared to be more that usual, in terms of incontinence. Staff B said she assisted her with cares and took her out to breakfast. She spoke to Staff D and they went to her apartment and a skin assessment was completed. There were no open areas but there was a reddened area. Staff B said Tenant #1 used her pendant all of the time and would call if she wanted to get up in the morning.

When interviewed on 7/20/25 at 2:00 p.m. Staff C said Tenant #1 brought it up to her that the night before she was put on the toilet and her pendant was left in the bathroom. She slept in the living room and was in her recliner. She said she was soaking wet. Tenant #1 was not on the list to be checked.

When interviewed on 7/23/25 at 11: 44 a.m. Staff D said Staff B told her about a situation and the Executive Director asked her to complete a skin assessment. Tenant #1 did not have her pendant throughout the night. Staff D completed a skin assessment and talked to Tenant #1. Staff D said believed Tenant #1 had a redness on her coccyx but it was not open. Tenant #1 was worried about getting someone in trouble.

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A 160	Continued From page 4 When interviewed on 7/22/25 at 12:05 p.m. Tenant #1 said staff got her dressed and she did not want to lay in bed. She said they both forgot the necklace (pendant) in the bathroom. She said she was getting ready for bed and could have gone to bed but wanted to relax and watch television. She normally slept in bed. She said she did not want to scream and wake everyone up. The staff covered her up in the recliner. She said the staff seemed to be an honest and true person. She said it was one of those things that happened. She said she was maybe a little bit more stiff the next morning. When interviewed on 7/22/25 the Wellness Director said she was out of the building when the Executive Director reported it to her. Staff B had gone in and checked on her that morning and she was in the recliner. She was assisted to the bathroom and her pendant was put on her. She could not verify but heard her pendant was in the bathroom. She said Staff A had either called or sent her a text message and asked to leave as she was not feeling well. Staff D picked up part of her shift. She said Staff A was notified she was suspended and was very upset She explained several times that it was an accident. The Wellness Director confirmed Tenant #1 required the assistance of one staff for transfers. She said Tenant #1 utilized her pendant but could not say how often without looking at the report. She had a reddened area but it was not open. When interviewed on 7/22/25 at 3:53 p.m. the Executive Director said Staff B reported Tenant #1 had been left in her recliner all night without a pendant. She said whoever, helped her to bed	A 160		

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A 160	Continued From page 5 assisted her to the recliner and said they would be back but did not return. She notified Tenant #1's family member and regional corporate staff. A skin assessment was completed and there was a red mark, she did not believe it was open. The Executive Director went and talked to Tenant #1 and she said she did not feel that it was on purpose. Tenant #1 really liked the caregiver and felt bad reporting it. Tenant #1 said the staff assisted her cares, the restroom and she was put in her recliner. Tenant #1 said she did not think to ask for her pendant. The Executive Director said an investigation was completed and Staff A was suspended. She said Staff A was upset and said she did not remember not putting the pendant back and was very apologetic. The Executive Director said she did not feel it was intentional. 2. Record review of an internal document, dated 7/30/25, regarding a fall with injury on 7/22/25 for Tenant #2 indicated Tenant #2 returned to the building on 7/21/25 at about 11:30 a.m. The Wellness Director told Staff B, E and I of Tenant #2's return and that she required the assistance of one person for most of her activities of daily living (ADLs). Throughout the night Tenant #2 fell. staff did not provide care for Tenant #2 due to the computer system indicating Tenant #2 was still on a leave of absence. Tenant #2's return to the building was passed on at shift change, in the nurse on-call system and the communication binder. It was thought Tenant #2 was on the floor unattended from about 3:00 a.m. to 5:15 p.m. Staff E was suspended pending the investigation. The Tenant #2 was sent to the hospital, had a dislocated hip and it was reduced. Tenant #2's power of attorney (POA) then reported to the Executive Director the hip reduction was not	A 160		

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successful and she had to have to surgery on 7/27/25. Tenant #2 was discharged from the hospital 7/28/25 with hospice services and comfort measures were initiated. Staff E returned to work on 8/1/25 and received education provided on 7/31/25 that included importance of service plans, task documentation and charting, expectations for documentation, tenant care levels and hospice documentation expectation. It was planned to have all staff receive education on 8/8/25 and all wellness nurses would be educated on 8/7/25 including on skilled charting, follow up charting, incident report, move in process and when a tenant returned, task charting and hot rack charting.

Continued record review of Tenant #2's file revealed Progress Notes indicated the following:

-On 6/8/25 staff found her in the living room wrapped in a blanket, laying on the ground when staff went in to give her medications. She was not able to describe what happened. Emergency medical services (EMS) was notified and took her to the hospital.

-On 6/19/25 Tenant #2's POA said she was admitted to a skilled care facility for therapies the previous Monday following hospitalization for weakness.

-On 6/30/25 staff at the skilled nursing facility (SNF) reported she remained on skilled therapy services. She had a few falls during her stay and there was no anticipated discharge date.

-On 7/14/25 it was noted Tenant #2 had multiple falls which led to a skilled nursing stay. She remained at the SNF due to ongoing falls and

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weakness. Her family explored the idea of long term placement at the skilled facility.

-On 7/21/25 (late entry) it was noted Tenant #2 returned from the skilled stay. Tenant #2 was a one person assist with a gait belt and walker. Staff administered her medications.

-On 7/23/25 (late entry) it was noted Tenant #2's fall with injury was discussed with the POA, who was upset. The POA was told she would be informed of the investigation results.

-On 7/23/25 (late entry) it was noted the POA emailed and said Tenant #2 had a dislocated hip and the ED doctor was able to put it back in place. She was in extreme pain, heavily sedated and immobile for now.

-On 7/28/25 it was noted Tenant #2's POA said the hip popped back into place did not work and she had regenerative hip surgery the day prior. The tenant would be in a brace for a week so she did not move.

-On 7/29/25 it was noted Tenant #2's POA emailed and said she was discharged yesterday, one day after her hip surgery and she was transferred to hospice for comfort cares and pain management.

Further record review of Tenant #2's file revealed a Comprehensive Resident Evaluation, dated 7/17/25, and signed by the Wellness Director on 7/21/25. The service plan, dated 7/22/25, was not signed and indicated indicated she would receive assistance with incontinence needs. It also indicated she would be groomed and dressed appropriately, as well as receiving

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assistance with transferring and mobility. It also indicated staff would administer her medications. The service plan reflected she would receive escort assistance. A Move-In Assessment was also completed, dated 7/21/25, and reflected her move in date and time as 7/21/25 at 11:30 a.m. It was not signed by the Wellness Director until 7/23/25.

The Discharge Order, Transition of Care and Discharge Instructions from the SNF with an effective date of 7/18/25 for discharge date of 7/21/25, indicated she required the assistance of one person with a walker. She was alert with intermittent confusion. A MORSE fall assessment, dated 7/17/25, indicated she scored an 80, which indicated high risk.

Continued record review of Tenant #2's July 2025 Medication Administration Audit Report and July 2025 MAR indicated Refresh Optive Advanced Solution, instill 1 drop in both eyes for times daily and as needed. It was documented as administered on 7/21/25 at 5:06 p.m. by Staff I. It was also documented as administered at 7:27 p.m. on 7/21/25 by Staff H. The July MAR reflected the oral medications scheduled at morning and bedtime on 7/21/25 and 7/22/25 were not charted or were charted as not administered due to being hospitalized. (It should be noted she returned to the building on 7/21/25 at 11:30 a.m.)

Further record review of the Documentation Survey Report for July 2025 indicated Staff B documented tasks on 7/21/25 at 6:27 p.m. including: continence assistance, escorting, grooming. The tasks were listed as Q shift (no specified times on the shift). Further record

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review failed to revealed documentation of completion of the following tasks:
- Continence assistance on the 7:00 p.m. to 7:00 a.m. on 7/21/25
-Dressing/undressing assistance on the 7:00 a.m. to 7:00 p.m. or 7:00 p.m. to 7:00 a.m. shift on 7/21/25.
-Grooming on the 7:00 p.m. to 7:00 a.m. shift.
-One-person physical assist with transfers on 7/21/25.

Additional review revealed Staff E documented the following on 7/22/25:
- 5:16 p.m. Staff E charted not applicable for continence and dressing/undressing
-5:17 p.m. Staff E charted the task of escorts was completed
-5:16 p.m. Staff E charted Tenant #2 was not applicable
-6:15 p.m. Staff E charted tenant unavailable for grooming.
-5:16 p.m. Staff E charted Tenant #2 was assisted with transfers/mobility. It was charted as independent and a walker was used.
(It should be noted she was found on the floor at 5:08 p.m. and these cares were charted as not applicable or completed after she was found on the floor.)

Continued record review revealed the census information on the dashboard of the electronic system indicated on 6/8/25 Tenant #2 was noted as on medical leave. On 7/21/25 it noted she was in house and on 7/22/25 it noted she was on medical leave. The Executive Director confirmed this change was made on 7/29/25 at around 4:00 p.m. for billing purposes. (It should be noted when the surveyor first viewed Tenant #2's record on 7/28/25 she was still reflected as on leave

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A 160	Continued From page 10 from 6/8/25.) Record review of the Program's timeline of events related to Tenant #2 indicated the following: -On 7/21/25 at 11:30 a.m. a notification was sent in the messaging application to indicate Tenant #2 had returned to the building. It was indicated as sent on the All Call Channel (Notify messaging application). -On 7/21/25 at 12:45 p.m. the Wellness Director completed an assessment. -On 7/21/25 at 6:07 p.m. Staff J provided a meal escort per the pendant review system. -On 7/21/25 at dinner Staff D was aware Tenant #2 had returned and was at dinner. Pharmacy had not delivered her medications. -On 7/21/25 (evening) Staff I administered eye drops to Tenant #2 per the medication administration record (MAR). -On 7/21/25 at 6:27 p.m. Staff B documented completion of cares for escorts, grooming and toileting. -On 7/21/25 at 7:27 p.m. Staff H administered eye drops to Tenant #2 per the MAR. -On 7/22/25 at 12:06 a.m. there was movement/light detected in the living room. -On 7/22/25 at 1:24 a.m. there was movement/light detected in the living room.	A 160		

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A 160	Continued From page 11 -On 7/22/25 at 12:22 p.m. the Executive Director spoke with Tenant #2's POA regarding new care points. -On 7/22/25 at 5:08 p.m. Tenant #2 was found on the floor by the Plant Operations Director. -On 7/22/25 at 5:12 p.m. Staff G responded to the pendant call. -On 7/22/25 at 5:15 p.m. Staff E documented tasks for Tenant #2. -On 7/22/25 at 5:50 p.m. Tenant #2's family was notified of the fall, that EMS was called and Tenant #2 was at the hospital. -On 7/24/25 at 10:41 a.m. Tenant #2's physician was notified of the fall and hospitalization. Record review revealed hospital records indicated she was seen in the emergency department (ED) on 7/22/25 at 6:08 p.m. She was admitted from the ED on 7/22/25 at 8:10 p.m. She was discharged from the hospital on 7/28/25. Visit diagnoses included: dislocation of the right hip, sepsis with encephalopathy, dislocation of the internal right hip prosthesis, severe sepsis without septic shock, metabolic encephalopathy and senile dementia. The report indicated she was found on the floor on 7/22/25, last known time she was well was 7/21/25 at noon. Her fall was unwitnessed. She had right facial droop and drooling and an inward facing right foot. A right hip reduction was completed at 6:51 p.m. The records indicated she had a dislocation of bipolar prosthesis right hip. Reduction was completed, "acetabular component remains posterior but femoral	A 160		

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component appears reduced." It was not likely she was a surgical candidate. She would be admitted for sepsis work up and management and pain control. It indicated she was diagnosed with a hemiarthroplasty dislocation and attempted reduction was completed in the ED. "There was dissociation of her arthroplasty components and orthopedics was consulted." Family elected to proceed. The records indicated on 7/27/25 a revision or right hip hemiarthroplasty was completed. The diagnosis was disassociated right hip hemiarthroplasty. The date of discharge was 7/28/25 at 1:57 p.m. and the disposition was intermediate care facility (ICF). The principal problem was acute metabolic encephalopathy. Active problems included fall, right hip dislocation and severe sepsis. The records indicated she was admitted for a concern with acute metabolic encephalopathy, history of dementia, urinary tract infection and fall was evaluated by orthopedic surgery and "underwent orthopedic procedure additionally goals of care discussion with palliative care and family/patient." Tenant #2 would be discharged to ICF with hospice.

Continued record review of pendant history records indicated Tenant #2's pendant was pressed on 7/21/25 at 5:56 p.m. and closed at 6:03 p.m. The next pendant call was on 7/22/25 at 5:10 p.m. (when she was found on the floor).

Further record review of the communication binder indicated on 7/21/25 a note recorded that indicated Tenant #2 returned at 11:30 a.m. The communication binder on 7/22/25 indicated Tenant #2 returned yesterday and fell today, she was getting sent out (hospital).

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A 160	Continued From page 13 Continued record review of messages between the Wellness Director and pharmacy indicated on 7/17/25 the Wellness Director asked why all of Tenant #2's medications were discontinued. The pharmacy response indicated the census dated 6/12/25 indicated she was on medical leave and they had not received anything about her being readmitted. She had been completely discharged on the pharmacy side. A response was sent back that indicated she would be re-admitted on Monday. When interviewed on 7/30/25 at 1:15 p.m. the Plant Operations Director said Tenant #2 had just gotten back the day prior and he had been told she had lost her key fob. He went to the apartment to test it and give her the fob. He knocked and heard something. He observed her on the floor between the walker and recliner. She was facing the doorway, her left arm was on the chair and her right leg was tucked under her, bent at a weird angle. Her walker was right beside her and was upright. The right arm covered her ear, the blanket was against her ear and head. She was wearing night clothes. She could not say what happened. He ensured she was not tangled in her walker, then sent a message in Notify to the wellness team that he needed help in her apartment. Her pendant was located on the stand next to her recliner. He pushed her pendant and Staff E arrived. Staff E said he would go and get a nurse. Shortly after the Wellness Director and Staff G arrived. The Wellness Director asked Staff E to call an ambulance. Tenant #2 did not want to lean back and staff kept her still until EMS arrived. He said she was wearing a nightgown and her brief appeared to be full. He had not seen her prior to that time.	A 160		

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A 160	Continued From page 14 When interviewed on 8/5/25 at 11:03 a.m. Staff E said he worked 7:00 a.m. to 7:00 p.m. and was responsible for first floor cares from 7:00 a.m. to 1:00 p.m. and cares for all three floors from 1:00 p.m. to 7:00 p.m. He said he could not remember if he heard anything at shift report from off-going staff for Tenant #2. As far as he knew she was not in the building. The POC (tasks) indicated she was on a leave of absence. He said she did not use her pendant that day and he was not aware she was there, as he did not see her. There were multiple things going on that day and he heard the Wellness Director say something but it was not clear enough. He did not remember when in the shift she said something to him and estimated maybe mid-morning or midday. He did not know if there was something noted in the communication book regarding her return. He said the Plant Operations Director put on Notify to come to the apartment as soon as possible. He went and observed Tenant #2 in front of her chair in an awkward position. He thought both of her legs were bent back underneath her. Her pendant was on the counter. The Wellness Director came to the apartment and told him to call 911. He directed EMS to the apartment once they arrived, where the Plant Operations Director, the Wellness Director and Staff G were, then left. At the end of the night staff still had to chart not applicable if a tenant was on a leave of absence or it would be red in color. If everything was charted it turned green. He charted not applicable for her cares after but before the end of his shift. He said he felt there was a communication barrier and he did not hear clearly. He was doing multiple things including helping another tenant move to another	A 160		

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A 160	Continued From page 15 apartment on a different floor. Record review revealed Staff E had provided three statements to the Program. The first statement indicated on 7/22/25 he was the care partner on first floor. He was in the middle of many things and the Wellness Director mentioned if he knew that Tenant #2 was back and he said yes but did not process what was said. He apologized for the incident and said he would never neglect a tenant or not give proper care. He said it was a misunderstanding. She was on leave in the computer system and he did not know her cares as it said she was on leave. He said no one would have gone to her apartment because of what the computer indicated. In his second statement he indicated he wanted to add information to his prior statement. He noted he was moving a tenant from one apartment to another apartment, completing laundry and investigating a bed bug situation. The Wellness Director came to him, he was very busy and heard her say something but he did not process that the person (Tenant #2) was back. He checked the computer and it said she was on leave. He was also the only care partner (cares) from 1:00 p.m. to 7:00 p.m. The other two staff on the floor were assisting with medications. He said it got a little overwhelming and confusing. He said the computer said she was on leave so he would not look on the computer at her cares. In a third statement (text message exchange) provided when asked about the charting, he said he did not chart on her cares specifically. He said there was a mistake as he just put not applicable on her chart since it indicated she was on leave. When asked why it was charted not applicable after Staff E called 911 and knew she was in the building, he	A 160		

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A 160	Continued From page 16 responded that it was accident. When interviewed on 8/5/25 at 10:08 a.m. Staff G said he was not present for report and he worked second floor and memory care medications from 7:00 a.m. to 7:00 p.m. When he went in Staff H and Staff K were talking about Tenant #2's being back. He said she was on leave in POC. He did not provide cares, services or administer medications to Tenant #2. She also did not call using her pendant. He did not see her out for meals. He did not see the communication book and had not been at report. Prior to hearing from third shift staff, he was not aware she was in the building. He was passing medications on second floor and saw a message on Notify (messaging application) that indicated assistance was needed. He said Tenant #2 was in pain in her lower back. Staff E was there with a vitals cart. The Wellness Director called family and EMS was called. Her blood pressure was elevated, he thought it was 195/85. Her legs were bent back in the shape of the letter M. She was slouched over with a blanket. Her pendant was on the table next to the recliner. She was incontinent of bladder, he said it was dark urine and there was a urine odor. EMS got her up and onto the stretcher. It was close to the end of the shift. He heard the Wellness Director talking to Staff E regarding Tenant #2. The Wellness Director asked Staff E if he remembered her telling him that she had returned and he thought it was that she would be returning. He said Staff E was also asked about cares marked off. Staff G said everyone felt bad about the situation and wished more could have been done. When interviewed on 8/4/25 at 11:09 a.m. Staff D reported she heard someone say that Tenant #2	A 160		

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was back. She did not see her and did not provide any cares for her. She saw in the Notify application that staff were checking on her. She saw in Notify that she had been down to dinner. Her medications were not there. She said the pharmacy was out of state and pharmacy had her orders. She was told Tenant #2 was a one assist, prior to that she was independent.

When interviewed on 8/4/25 at 10:38 a.m. Staff B said staff was informed via the Notify system that Tenant #2 had returned. She had been out weeks prior to that. The Wellness Director informed her that Tenant #2 needed additional cares from what she received prior and she needed hands on assistance including with toileting. In the afternoon she went to her apartment and got her water and asked if she needed to use the bathroom and she did not. She reminded her to use her pendant and she did not use it until after supper. She went back a few hours later and assisted her to bathroom, walked with her with a gait belt and stand by assistance to the dining room. She put in the communication book that Tenant #2 had returned and would need more cares. One of the other staff, Staff J assisted her after.

Staff B provided a statement indicated on 7/21/25 Tenant #2 returned to the building around 11:30 a.m. She went to her apartment that afternoon (not able to recall time). She got her some water, made sure she was doing okay and reminded her to use her pendant if she needed assistance. She returned early evening and took her to the bathroom. She walked with her to the dining room for supper. She wrote in the communication book that she was back and the night shift was notified she was there and that

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A 160	Continued From page 18 she needed additional assistance with cares. When interviewed on 8/4/25 at 11:25 a.m. Staff J said a message was sent out just before 12:00 p.m. that she was back. The Wellness Director also came into the nurse's station and told staff that she was a one assist with all cares. The Wellness Director said she wasn't sure Tenant #2 would be consistent with her pendant to check in on her every two to three hours. He said Staff B checked on her at least twice. He walked her back to her apartment after supper with stand by assistance. He helped her sit back in her chair at about 6:45 p.m. He said her medications were not available. He said it was noted in the communication book that she had returned and was a one assist with cares. Staff J provided a statement to the Program, dated 7/23/25, that indicated on 7/22/25 she was not aware that Tenant #2 had returned to the building. Her status in the system indicated she was on leave. He must have missed the report that indicated she was back and "acted based on the information in the system." When interviewed on 8/4/25 at 11:58 a.m. Staff I said a message was sent out in Notify that Tenant #2 was on her way back. The Wellness Director told her she was a one assist with all cares. She saw Staff B escorting her to a meal and she was walking with her and a walker. There were no medications available for Tenant #2. She administered her eye drop to Tenant #2 out of her apartment when she was going to the meal. That medication was available. She said it still showed Tenant #2 was on leave but all staff on first shift knew she was there. She said Staff B wrote in the communication binder everything	A 160		

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A 160	Continued From page 19 that was said at report. Staff I provided a statement that indicated on 7/21/25 she was aware Tenant #2 had returned to the building. She did not assist with any cares for her. There was a message sent out in Notify and the Wellness Director came to her and Staff B and reported she was back and she would be an assist of one person with cares. Staff B and Staff I told the next sheet that came in that she was back in the building and would require the assistance of one person with all cares. When interviewed on 8/4/25 at 3:12 p.m. Staff K said she was supposed to work 7 a.m. to 11:00 a.m. but stayed until 1:00 p.m. When she got there that morning it was Staff E and Staff F for day shift and Staff H from night shift. Staff H said that Tenant #2 had come back. Staff K worked second and third floor cares and Staff E worked first floor cares. She said it still noted in POC that Tenant #2 was on leave. It was switched before she left. She said staff did not ask for help with her and she did not use her pendant. She figured she was taken care of. She did not see her or go to her apartment. She said Tenant #2 was not out for meals but she did not realize it. She said it standard protocol when people came back from the hospital to check on them every two hours. Staff K provided a statement dated 7/23/25 that indicated she worked on 7/22/25 from 7:00 a.m. to 1:00 p.m. Night shift staff reported that Tenant #2 was back in the building but was back with hospice care and nothing else was said regarding cares or medication needs or any changes to her service plan. She worked second and third floors and helped out on first floor when	A 160		

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needed. Staff K did not see Tenant #2 on her shift and Tenant #2 did not use her pendant. Staff did not ask for assistance with Tenant #2 and she figured she was being taken care of between Staff F (medication passer) and Staff E (cares). She noticed in the electronic record system that Tenant #2 was still on leave at the beginning of the shift but it had been changed before she left for the day.

When interviewed on 8/4/25 at 3:32 p.m. Staff H said at shift change she was informed Tenant #2 was back and the medications were not in the cart. She looked through the medication cart and found eye drops. She was noted as on leave in the system. She went to her apartment, administered her eye drops and told her if she needed anything to use her pendant. When Staff H left Tenant #2 was seated in her chair, covered up. There were no safety checks told to staff. There were no pendant calls from Tenant #2.

Staff H provided a statement dated 7/25/25 that indicated on Monday when she arrived to work, she was informed during report that Tenant #2 had returned and her medications were not in the cart. When she was going over her medication cart she noticed Tenant #2 had some eye drops that were scheduled on the MAR. She was still on leave in the system. She went to her apartment, knocked on the door, went into her apartment and greeted her. She was sitting in her recliner, under a blanket and was watching television. Staff H administered her eye drops and reminded her to use her pendant is she needed anything. That was her last interaction with her.

When interviewed on 8/5/25 at 9:53 a.m. Staff F

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said she was working 7 a.m. to 7 p.m. on first and third floor medications. She did not hear anything at report. She did not provide any services to Tenant #2. She said in the computer it was noted she was on a leave of absence and her medications were not available to administer. It showed she was still on leave in the MAR. She did not have any pendant calls that day that she responded to. She was not out meals but was usually was just out for dinner, sometimes lunch. She did not see Tenant #2 out of her apartment that day. She said the Wellness Director walked up and gave her a box of medications and said Tenant #2 had returned yesterday. At that time Staff E came out and said Tenant #2 had fallen and the Plant Operations Director was in the apartment. The Wellness Director went into the apartment. She went to the nurse's station and saw in the communication book that she had returned. Staff E called an ambulance. Staff G and Staff F tried to get emergency paperwork ready but it would not print. The Wellness Director got it for the staff. Staff F indicated a statement had been provided; however, the statement was not available when requested.

When interviewed on 8/5/25 at 1:23 p.m. the Wellness Director said Tenant #2 had gone out (hospital and SNF care) when she was out of the building. She went to assess her on Thursday (7/17) and she came back on Monday (7/21). She returned at 11:30 a.m. and she went to see her. She needed more assistance, including SBA with walker to walk, hands on assistance with bathing, dressing and grooming. Hands on assistance with toileting and medications. A message was sent out in Notify regarding her return. She talked to Staff B regarding Tenant #2 being back and she explained her care needs.

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A 160	Continued From page 22 She had sent a message to pharmacy on Thursday or Friday before she came back regarding her medications. She touched base with Staff E to let him know she was back around 9:30 a.m. to 10:30 a.m. Staff E did not know that based on report. He said he would check in on her. At 5:10 p.m. she was walking down the hallway and Staff E came out and said she was needed in Tenant #2's apartment. When she went in the Plant Operations Director was there, he was working on her fob and he pressed her pendant. Staff G also arrived and Staff E had just walked out. She was seated on the floor in front of her recliner with her knees together and her feet apart. She did not have any visible injuries. She asked Tenant #2 what happened and did not receive a response. She had low back pain. The Plant Operations Director said the pendant was on the table next to the chair. She said Tenant #2 typically slept in bed. Staff E came back in and she asked him to call EMS. She sat on the floor next to Tenant #2. Her blood pressure was elevated. EMS came to the apartment and they assisted with getting her up off of the floor. The face sheet and medication list were provided to EMS. When they took the paperwork they were on the phone with the family. She called the Executive Director and she communicated with corporate staff. Before she left that night they called and had a discussion with the POA. She was very disappointed. She said both her and the Executive Director were upset and disappointed with the situation. They got a statement from Staff E and he was placed on suspension pending investigation. She said Tenant #2 had a dislocated hip, it was reduced successfully. In the day or two, there was a surgical intervention and comfort cares were put into place. She said	A 160		

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A 160	Continued From page 23 on their Augi system (fall prevention system) there was no movement by day shift staff until 5:08 p.m. During that time she would have needed assistance with transfers, dressing, grooming and continence. She said when reviewing the documentation it was noted Staff E had signed off cares at 5:15 p.m. as both not applicable and a couple signed off as completed. She said typically when a tenant went on leave the operations coordinator would put the tenant on leave of absence and then back into the system. She said the operations coordinator was on vacation that week. She said Tenant #2 was not on safety checks. She said hot charting was done to track acute things, falls, antibiotics, infections falls. It was a trigger to observe and it was not completed for Tenant #2. She said one to one training was completed with Staff E regarding service plans and documentation in real time. It was not confirmed but was estimated she was on the floor from right before 3:00 a.m. to 5:00 p.m. The Wellness Director provided a statement dated 7/30/25 that indicated on 7/21/25 at about 11:30 a.m. Tenant #2 returned to the Program with her family. The receptionist sent a message in Notify (messaging application) that indicated Tenant #2 had returned. The Wellness Director saw her at about 12:35 p.m. to complete her assessment. She reminded her to use her pendant to call staff when she needed assistance and that she should call for assistance when she was going to get up. She spoke with Staff B and notified her of Tenant #2's return and that she needed more assistance with ADLs than she had previously needed. Staff B wrote in the communication book that Tenant #2 had returned. On 7/22/25 at 5:10 p.m. the Wellness	A 160		

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A 160	Continued From page 24 Director went to Staff F who was at the medication cart, to deliver medications that needed to be put into the medication cart. Staff F asked if Tenant #2 was back and she was told she returned yesterday. At that time Staff E came towards her and said that she needed to go to Tenant #2's apartment. She went to the apartment and found the Plant Operations Director and Tenant #2, who was sitting "very uncomfortably" on the living room floor in front of her chair. After observing her, the Wellness Director believed she had a hip injury and did not move her. She instructed Staff E to call EMS and she stayed with her. Tenant #2 was not able to report what had occurred. EMS arrived and she was assisted off of the floor. They believed she had a broken hip. EMS took Tenant #2 outside to the ambulance and called her POA. The Wellness Director returned to her office and called the Executive Director. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director said the Wellness Director called her and said it was really bad, Tenant #2 had an unwitnessed fall and she had never seen anyone positioned the way she was. She did not believe anyone had checked on her on the day of the incident. The Executive Director called her boss and then the Executive Director and Wellness Director called Tenant #2's POA. She said the POA was upset and asked how it could happen. When Tenant #2 came back to the building she was an assist of one person with all cares. She was set up for escorts to the dining room, grooming, dressing assist. The Executive Director started the investigation. She reviewed key fobs, call pendant history, the Augi system. She said the Augi system was not clear on anything. Regional corporate staff estimated the	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0463	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARSTONE SENIOR LIVING	4715 ALGONQUIN DRIVE CEDAR FALLS, IA 50613

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A 160	Continued From page 25 time was from 3:30 a.m. to 5:00 p.m. Her pendant was used once on 7/21/25 and once on 7/22/25 (by the Plant Operations Director). She had no scheduled services overnight and no safety checks. She said Staff E received reeducation and in-service was scheduled for 8/7/25 with all staff. She said reports at shift changes were also changed to cover each person. Staff E said he recalled the Wellness Director saying something but not specifically that she returned. He was busy and the floor was short staffed. She said she did not think the medications were delivered for Tenant #2. She said the leave of absence for Tenant #2 was not closed out in the system but staff were informed by the nurse, the call system and the communication binder. She said despite it not being updated the MARs and POC (tasks) showed up. Family initially reported the hip was dislocated and was reduced but was not successful. She had hip surgery on Sunday. It was determined she would discharge from the hospital and would receive hospice and comfort cares. The facility she discharged to was not known. She confirmed hot charting was not implemented for Tenant #2. It was typically done with antibiotics, falls, new tenants, returned tenants.	A 160		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses'	A 290		

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A 290	Continued From page 26 notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 1 of 2 current tenants reviewed (Tenant #1) and 1 of 1 discharged tenant reviewed (Tenant C1). Findings follow: 1. Record review on 7/21/25 of Tenant #1's file revealed Progress Notes indicated the following: -On 5/14/25 an order was received for cephalexin 500 milligram (mg) capsules, one capsule by mouth three times daily for seven days. -On 5/26/25 a head to toe skin check was completed. There was redness/breakdown observed on her buttocks. The notes indicated the area was not open but it appeared to be breaking down and was red. The location of the wound was on her coccyx. -On 5/30/25 a head to toe skin check was completed. It was noted as a red/irritated area to her buttocks. Barrier cream was advised. -On 6/5/25 Tenant #1 complained of burning with urination and reported she increased incontinence. She said she felt better for a few days after the last course of antibiotics and her symptoms had begun to show up again. An order was received for a urinalysis with culture and sensitivity. -On 6/9/25 noted a new order was received for	A 290		

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A 290	Continued From page 27 levofloxacin 500 daily for 10 days. -On 6/11/25 levofloxacin was prescribed for a urinary tract infection (UTI) and the tenant had no adverse reactions. -On 6/13/25 it was noted Tenant #1 had no adverse reactions (related to the levofloxacin) and was afebrile. Continued record review revealed nurse's notes were not documented by exception related to the completion of the two courses of antibiotics and to follow up on further signs or symptoms of a UTI. A nurse's note was also not completed related to follow up to the redness/irritation that remained on Tenant #1's buttocks as noted on 5/30/25. 2. Record review on 7/21/25 of Tenant C1's file revealed Progress Notes indicated the following: -On 6/24/25 it was noted on 6/24/25 Tenant C1 had a bruise on her left elbow that measured 4 centimeters (cm) by 2.6 cm. She rated her pain at a 7 out of 10. It was noted the area appeared to be new due to the dark purple color with a 1 cm blood blister in the center. -On 6/27/25 it was noted Tenant C1 reported she still had pain in her elbow, she said it was rated at 3. Continued record review revealed nurse's notes were not completed to follow up on the bruise on Tenant C1's elbow and her complaints of pain related to the area. 3. When interviewed on 8/4/25 at 1:58 p.m. the	A 290		

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A 290	Continued From page 28 Executive Director confirmed all nurse's notes were provided for the tenants reviewed.	A 290		
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) This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete incident reports when required. This pertained to 1 of 2 current tenants reviewed (Tenant #2). Findings follow: 1. Record review of an internal document dated 7/30/25 regarding a fall with injury on 7/22/25 for Tenant #2. It indicated Tenant #2 returned to the building on 7/21/25 at about 11:30 a.m. The Wellness Director told Staff B, E and I of Tenant #2's return to the building and that she required the assistance of one person for most of her activities of daily living (ADLs). Throughout the night Tenant #2 fell. Staff did not provide care for Tenant #2 due to the computer system indicating Tenant #2 was still on a leave of absence. Tenant #2's return to the building was passed on at shift change, in the nurse on-call system and the communication binder. It was thought Tenant #2 was on the floor unattended from about 3:00 a.m. to 5:15 p.m. Tenant #2 was sent to the	A 320		

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A 320	Continued From page 29 hospital, had a dislocated hip and it was reduced. Tenant #2's power of attorney (POA) then reported to the Executive Director the hip reduction was not successful and she had to have to surgery on 7/27/25. Tenant #2 was discharged from the hospital 7/28/25 with hospice services and comfort measures were initiated. 2. When interviewed on 8/5/25 at 1:23 p.m. the Wellness Director said Tenant #2 had gone out (hospital and skilled nursing facility care) when she was out of the building. She assessed her Thursday (7/17) and she came back Monday (7/21). She returned at 11:30 a.m. and she went to see her. She needed more assistance, including stand by assistance (SBA) with her walker to walk, hands on assistance with bathing, dressing and grooming. Hands on assistance with toileting and medications. A message was sent out in Notify (messaging application) regarding her return. She talked to Staff B regarding Tenant #2 being back and she explained her care needs. She touched base with Staff E to let him know she was back around 9:30 a.m. to 10:30 a.m. Staff E did not know that based on report. He said he would check in on her. At 5:10 p.m. she was walking down the hallway and Staff E came out and said she was needed in Tenant #2's apartment. When she went in the Plant Operations Director was there, he said he had been working on her fob and he pressed her pendant. Staff G also arrived and Staff E had just walked out. She was seated on the floor in front of her recliner with her knees together and her feet apart. She did not have any visible injuries. She asked Tenant #2 what happened and did not receive a response. She had low back pain. The Plant Operations	A 320		

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A 320	Continued From page 30 Director said the pendant was on the table next to the chair. She said Tenant #2 typically slept in bed. Staff E came back in and she asked him to call emergency medical service (EMS). She sat on the floor next to Tenant #2. Her blood pressure was elevated. EMS came to the apartment and they assisted with getting her up off of the floor. The face sheet and medication list were provided to EMS. When they took the paperwork they were on the phone with the family. 3. Record review on 7/28/25 to 7/30/25 of Tenant #2's file revealed Progress Notes indicated the following: -On 7/21/25 (late entry) Tenant #2 returned from the skilled stay. Tenant #2 was a one person assist with a gait belt and walker. Staff administered her medications. -On 7/22/25 (late entry) Tenant #2's fall with injury was discussed with the power of attorney (POA), who was upset. The POA was told she would be informed of the investigation results. Continued record review revealed an incident report was not completed related to the incident on 7/22/25. 4. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all incident repots were provided for the tenants reviewed.	A 320		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and	A 350		

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A 350	Continued From page 31 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed and failed to reflect the service needs of the tenant. This pertained to 1 of 2 current tenants reviewed (Tenant #2) and 1 of 1 discharged tenant reviewed (Tenant C1). Findings follow: 1. Record review on 7/28/25 to 7/30/25 revealed Tenant #2's unsigned service plan, dated 7/22/25, reflected Tenant #2 would be groomed appropriately. It indicated for bathing she would receive bathing assistance. For dressing Tenant #2 would be dressed appropriately. For transfers and mobility she would receive assistance and she would receive assistance with escorts. Continued record review of an internal document, dated 7/30/25, regarding a fall with injury on 7/22/25 for Tenant #2 revealed Tenant #2 returned to the building on 7/21/25 at about 11:30 a.m. The Wellness Director told Staff B, E and I of Tenant #2's return to the building and that she required the assistance of one person for most of her activities of daily living (ADLs). When interviewed on 8/5/25 at 1:23 p.m. the	A 350		

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A 350	Continued From page 32 Wellness Director said Tenant #2 had gone out (hospital and skilled nursing facility care) when she was out of the building. She assessed the tenant on Thursday (7/17) and she came back on Monday (7/21). She returned at 11:30 a.m. and she went to see her. She needed more assistance, including stand by assistance with walker to walk, hands on assistance with bathing, dressing and grooming. Further record review revealed a service plan was developed when Tenant #2 returned to the building; however the service plan was not specific to Tenant #2 care needs as indicated above. 2. Record review on 7/21/25 of Tenant C1's file revealed Progress Notes indicated the following: -On 6/4/25 an order was received to apply Triad wound paste to the coccyx every three days, cover with Mepilex 4 x 4 every three days and as needed if soiled. The wound was two centimeters (cm) by 1 cm. It was noted a pressure wound. -On 6/6/25 skilled services were provided by hospice and the Program. It was noted the wound was 2 cm by 1 cm. The order for the wound was to apply Triad cream to area and cover with Mepilex every three days and as needed if soiled. -On 6/18/25 it was noted Tenant C1's family requested partial dressing assistance added to her services and three time per week bathroom cleaning. It was noted she was getting weaker, needed dressing assistance, did not routinely wear an adult brief and needed assistance due to	A 350		

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A 350	Continued From page 33 urine getting on the bathroom floor. Continued record review revealed the Comprehensive Resident Evaluation, dated 6/18/25, indicated Tenant C1 had a cane, walker and wheelchair for medical equipment. It also indicated Tenant C1 had a closed pressure sore. The wound treatment was to be completed per physician's order. Care was provided by hospice and medication partners (staff). Further record review revealed the June medication administration record (MAR) reflected the order to apply Triad cream to coccyx, cover with Mepilex dressing, change every three days and as needed if soiled. Staff initialed for the completion of the treatment. Continued record review revealed an incident report dated 6/24/25 indicated Tenant C1 reported someone told her she needed to leave her apartment while the carpet was cleaned and then someone came and put her into a wheelchair and put her outside of her apartment and left her there. Continued record review revealed the service plan indicated Tenant C1 would be dressed appropriately but did not indicate the type of assistance required for dressing. The service plan reflected Tenant C1 used a cane and had a walker but rarely used it. The service plan did not indicate the use of the wheelchair as noted above. The service plan reflected Tenant C1 had hospice and the nurse managed the wound on her buttocks. It did not reflect staff assistance with the wound treatment. 3. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all service plans	A 350		

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A 350	Continued From page 34 were provided for the tenants reviewed.	A 350		

ok
10/6/25

PLAN OF CORRECTION

Provider/Supplier Name:	CEDARSTONE SENIOR LIVING- Assisted Living
Street Address, City, Zip:	4715 ALGONQUIN DRIVE, CEDAR FALLS, IA 50613
Date of Survey:	08/05/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency cited are correctly applied. Any changes to the community policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies.	
A 160	**Correction of Cited Deficiency:** Resident #1- Care staff have been in-serviced on important of replacing pendants back on residents after it is removed for showering or other needs. Resident #2- no longer resides at community, but the resident had been reactivated into Point Click Care as soon as that issue was identified	#1 8/7/25 #2 7/22/25
	Assessment to Identify other Residents that may be affected: Care staff have been in-serviced on important of replacing pendant back on resident after it is removed for showering or other needs and to confirm when staff attend to residents to make sure residents are wearing pendants. Community ensured all residents in the community were properly activated in Point Click Care	10/3/2025
	Procedure to ensure on-going compliance: The Wellness Director or her designee will do regular checks to	10/10/2025

	ensure residents are wearing pendants. The Wellness Director or Wellness Nurse will ensure residents are properly evaluated and that service plans accurately reflect their care and service needs. Residents moving in or returning from a leave of absence will be reactivated in Point Click Care upon return with a protocol in place for who is responsible for reactivating the resident. The Manager on Duty will meet with all residents moving in or returning over the weekend and verify with the Nurse Manager that they are active in Point Click Care. The Executive Director will audit all move-ins for the next two months to confirm ongoing compliance.	
	Monitoring for on-going compliance: Care staff have been in-serviced on importance of replacing pendant back on resident after it is removed for showering or other needs and to confirm when staff attend to residents to make sure residents are wearing pendants. The Wellness Director or her designee will do regular checks to ensure residents are wearing pendants. The Executive Director will review audit results during the weekly Department Head meeting for a period of two months to ensure continued compliance.	10/3/2025
A 290	**Correction of Cited Deficiency:** Resident #1-progress notes include skilled therapy notes, medication changes, and increased documentation from last review. Resident #C1-no longer resides at the community.	9/1/2025
	Assessment to Identify other Residents that may be affected: Wellness staff have been re-educated on charting by exception and the importance of ensuring that monthly progress notes include adequate detail to the responsible party on the care received.	10/3/2025
	Procedure to ensure on-going compliance: An in-service was provided to staff emphasizing that progress notes must capture significant issues, including but not limited to antibiotic use, therapy involvement, home health or hospice support, and any other events that require documentation in the 24-hour report.	10/3/2025
	Monitoring for on-going compliance: The Executive Director will review the 24-hour report with the Wellness Director and Memory Care Director for a period of three months to ensure that all relevant information is appropriately documented in the progress notes.	10/3/2025
A 320	**Correction of Cited Deficiency:** Resident #2- no longer resides at the community but incident report from 7/22/25 incident was completed	8/19/2025
	Assessment to Identify other Residents that may be affected: Inservice on Incident Reports was held with Wellness Nurses. No other residents identified.	10/3/2025
	Procedure to ensure on-going compliance: The Wellness Director and Memory Care Director will meet daily with the Executive Director to review the 24-hour report and initiate Incident Reports when warranted. All Incident Reports will be reviewed to ensure proper documentation, including	10/6/2025

	follow-up actions, is completed in accordance with policy.	
	Monitoring for on-going compliance: The Wellness Director will present a summary of all incident reports during the weekly Department Head Meetings for a period of three months to ensure continued compliance.	10/10/2025
A 350	**Correction of Cited Deficiency:** Resident #2-no longer resides at the community. Resident #C1- no longer resides at the community. Service Plans are formally closed when a resident discharges.	10/3/2025
	Assessment to Identify other Residents that may be affected: The Wellness Director or designee will conduct audits of service plans following each significant change in condition or annual assessment to ensure timely and accurate updates. Staff have received in-service training emphasizing that service plans must be updated at least annually and after any significant change in condition, including return from hospitalizations or short-term rehabilitation stays.	10/3/2025
	Procedure to ensure on-going compliance: The Wellness Director or designee will conduct audits of service plans following each significant change in condition or annual assessment to ensure timely and accurate updates. Audits will be conducted over a three month period to ensure compliance.	10/10/2025
	Monitoring for on-going compliance: The Wellness Director will present audit findings during weekly Department Head Meetings for three consecutive months to confirm adherence to service plan requirements.	10/10/2025