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 02/09/2026

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. Tenants without cognitive impairment: 54 Tenants with cognitive impairment: 6 Total census: 60 No regulatory insufficiencies were cited during the investigation of Complaint #130889-C. Regulatory insufficiencies were cited during the investigation of Complaint #130913-C, Complaint #130964-C, and Mandatory Report #131405-A. Regulatory insufficiencies were recited during the revisit for FC#10907 for the prior investigation of Incidents #128992-I, #129591-I, and #130033-I from 8/05/25.	A 000	See attached POC 4/9/26	
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 interviews and record reviews, the Program failed to follow established policies for internal investigations of abuse and the reporting of suspected abuse for 1 out of 7 tenants (Tenant #2). Findings follow: Record review on 2/04/26, revealed Tenant #2's incident report, dated 12/29/25, noted Tenant #2 reported a Medication Partner was rude and	A 150		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 150	Continued From page 1	A 150		

rough during cares. Tenant #2 reported the Medication Partner grabbed her breast when she was rolled over in bed. Tenant #2 requested the Medication Partner not work with her anymore.

Tenant #2's service plan, dated 10/17/25 reflected Tenant #2's staff assistance included: grooming, bathing, dressing, transferring/mobility, bed mobility, escorting, evacuation, cognition, medication management, physical/occupational therapy, laundry, housekeeping, and reporting any concerns with abuse/neglect.

Continued record review revealed the Program's internal investigation, started on 12/29/25 regarding Tenant #2's allegations. The investigation included a statement from Tenant #2, statements from Staff E and Staff F, and video footage from Tenant #2's apartment. All staff statements were dated 12/29/25. No other documents were provided as part of the internal investigation.

When interviewed on 2/04/26 at 9:38 a.m., the Executive Director indicated the investigation was ongoing.

When interviewed on 2/04/26 at 1:19 p.m., the Executive Director reported she was out sick at the time Tenant #2's allegation surfaced. The Executive Director indicated the Regional Executive Director and the Business Office Director interviewed Staff E and placed her on suspension until the investigation was complete. Staff E remained on suspension as of 2/04/26. The Executive Director wanted to be sure all evidence was reviewed. She added she had been waiting on a final review from the regional team. The Executive Director confirmed the Program had not notified the Department of Inspections,

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A 150	Continued From page 2 Appeals, and Licensing (DIAL) of Tenant #2's allegation of abuse. The Program policy Investigations, dated 12/15/25, included the following directives: - Investigations were conducted promptly and impartially to ensure fairness, accuracy of information, and proper corrective measures were taken, if necessary. - Except where a shorter time frame is required by state law, any investigations related to residents were to be completed with all reports and supporting documents uploaded to the appropriate folder for audit within 72 hours. The Program policy Abuse and Neglect, Observed or Suspected, dated 7/31/24, included the following directives:. - The investigation was to be completed within 72 hours and sent to the Chief Executive Officer (CEO) and the Regional Director of Operations by the Executive Director prior to being submitted to state agencies. - The state agency was to be notified within two hours, or time frame as dictated per state guidelines, of awareness of the event/allegations by the Executive Director. When interviewed on 2/04/26 at 2:30 p.m., the Executive Director and the Operations Coordinator confirmed the Program failed to complete the investigation regarding allegations of abuse within 72 hours as the Program's Investigation policy and Abuse and Neglect, Observed or Suspected policies dictated. The Executive Director confirmed the investigation was pending 37 days after the allegation. The Executive Director and the Operations Coordinator further confirmed DIAL was not	A 150		

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A 150	Continued From page 3 notified of the allegations of abuse reported by Tenant #2.	A 150		
A 315	481-67.7(2)a Waiver of Criteria for Retention 67.7(2) Waiver petition procedures. The following procedures shall be used to request and to receive approval of a waiver from criteria for the retention of a tenant: a. A program shall submit the waiver request on a form and in a manner designated by the department as soon as it becomes apparent that a tenant exceeds retention criteria pursuant to an evaluation by a health care or human service professional. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the Program failed to obtain a waiver of the criteria of retention for 1 tenant reviewed who exceeded the Program's level of care criteria (Tenant C1). Finding follows: Record review on 2/04/26, revealed Tenant C1's file indicated an admission date of 9/27/25 with a diagnosis of amyotrophic lateral sclerosis (ALS). Tenant C1's last completed evaluations on 12/19/25, revealed the following: Tenant C1 had an indwelling urinary catheter. Staff provided catheter cares. Tenant C1 received medication administration assistance. Tenant C1 would require physical assistance for evacuation. Tenant C1 required staff assistance with bed mobility. Tenant C1 could not reposition herself in bed due to weakness. Tenant C1 was a two-person transfer utilizing a mechanical lift.	A 315		

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A 315	Continued From page 4	A 315		

Tenant C1 required complete assistance with eating. Staff hand fed meals and provided verbal cues to chew/swallow/drink. Tenant C1 was on hospice. Hospice provided bathing assistance.

2. When interviewed on 2/03/26 at 10:47 a.m., Staff B stated she worked with Tenant C1. Staff B reported Tenant C1 required 2 to 3 staff and a mechanical lift for transfers. Staff B added staff did not have to use the mechanical lift for long due to hospice implementing a catheter.

When interviewed on 2/04/26 at 9:27 a.m., Staff C stated she worked with Tenant C1. Staff C indicated Tenant C1 had a catheter and staff provided catheter cares. Staff C added Tenant C1 transferred to a commode using several staff and a mechanical lift prior to getting a catheter.

When interviewed on 2/04/26 at 9:46 a.m., the Care Coordinator reported the last two weeks at the Program Tenant C1 was bed bound. Staff routinely repositioned her. The Care Coordinator expressed Tenant C1 quickly declined and hospice became involved. Staff used a mechanical lift to place Tenant C1 on a commode for a brief while until 12/19/25 when hospice initiated a catheter.

When interviewed on 2/04/26 at 1:19 p.m., the Executive Director stated the Regional Executive Director worked on a waiver of the criteria of retention for Tenant C1 but was not sure if it was completed.

On 2/04/26 at 2:26 p.m., the Department confirmed no waiver of the criteria of retention was requested for Tenant C1.

When interviewed on 2/04/26 at 2:30 p.m., the

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A 315	Continued From page 5 Executive Director and the Operations Coordinator confirmed no waiver of the criteria of retention was requested for Tenant C1.	A 315		
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 an incident report when required for 1 out of 7 tenants reviewed (Tenant #6). Finding follows: Record review on 2/04/26, revealed Tenant #6's file indicated an admission date of 8/31/22. Tenant #6's service plan dated 3/14/25 included a severe cognitive impairment and received assistance with cognition. Severe impairment per a Brief Interview for Mental Status score (BIMS score) indicated Tenant #6 failed to identify the current year/month/day. Tenant #6 also had poor short-term memory recall. Staff supervised behaviors and guided as needed. Staff provided a supportive environment. A review of Tenant #6's nurse's notes revealed the following incident documented: On 12/10/25 at 12:10 p.m., Staff D was at the front desk and	A 320		

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observed Tenant #6 walking outside of the building. Tenant #6 told Staff D she thought she would walk home.
Tenant #6 was redirected to her apartment and Staff D notified her supervisor. Tenant #6 was placed on 15-minute safety checks until the following day. Tenant #6 was diagnosed and treated for a urinary tract infection on 12/26/25.

Further review of Tenant #6's record showed no incident report on file regarding Tenant #6's incident on 12/21/25.

When interviewed on 2/04/26 at 11:42 a.m., Staff D reported she was at the front desk when she observed Tenant #6 walking outside of the building. Staff D knew walking outside was abnormal for Tenant #6. When approached by Staff D, Tenant #6 stated she was not okay and thought she would walk home. Staff D stated it was cold outside but Tenant #6 had on a coat and shoes.

When interviewed on 2/03/26 at 10:47 am, Staff B indicated Tenant #6 had memory issues. Tenant #6 had times where she forgot she lived at the Program. Staff B expressed Tenant #6 really struggled with her memory.

When interviewed on 2/04/26 at 1:19 p.m., the Executive Director reported an incident report was not completed on Tenant #6's incident due to her living in the assisted living and not the alarmed memory care. The Executive Director indicated tenants were free to walk outside in assisted living. The Executive Director stated Tenant #6 was placed on 15-minute checks after the incident just to be safe.

A review of weather history on 2/04/26 via

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A 320	Continued From page 7 https://www.wunderground.com, revealed the temperature was 28 degrees Fahrenheit at 11:53 a.m. on 12/21/25. A review of the assisted living tenant roster upon entrance of the Program on 2/02/26, revealed Tenant #6 was identified as having a Global Deterioration Score (GDS) of four indicating a moderate cognitive decline. When interviewed on 2/04/26 at 2:30 p.m., the Executive Director and the Operations Coordinator confirmed the incident Tenant #6 had on 12/21/25 was unusual and no incident report was completed.	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 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 develop the service plan based off of evaluations and update the plan as needed for 1 out of 7 tenants reviewed (Tenant C1). Finding follows:	A 350		

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A 350	Continued From page 8 Record review on 2/03/26, revealed Tenant C1's last completed functional, health, and cognitive evaluations were completed on 12/19/25 due to a significant change. The health/functional evaluation indicated Tenant C1 had an indwelling urinary catheter placed by hospice. The evaluation added Tenant C1 required assistance with catheter care. Tenant C1's last implemented service plan dated 12/19/25 failed to identify Tenant C1 had an indwelling urinary catheter added and staff were to provide catheter care assistance. When interviewed on 2/04/26 at 9:46 a.m., the Care Coordinator reported hospice provided Tenant C1 with an indwelling catheter in the last few weeks of her life due to being bed-bound. The Care Coordinator recalled the significant change evaluations completed on 12/19/25 were due to the addition of the catheter. When interviewed on 2/04/26 at 2:30 p.m., the Executive Director and the Operations Coordinator confirmed Tenant C1's 12/19/25 service plan failed to identify Tenant C1 had an indwelling urinary catheter and required staff assistance for catheter cares.	A 350		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance	A 395		

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A 395	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the Program failed to ensure the service plan was individualized and included all identified needs for 3 out of 7 tenants (Tenant C1, Tenant #2, Tenant #3). Findings follow: 1. Record review on 2/03/26, revealed Tenant C1's last completed functional, health, and cognitive evaluations were completed on 12/19/25. The health/functional evaluation indicated Tenant C1 received the following assistance: a. Tenant C1 required complete toileting and continence assistance. The evaluation further added the service plan goal should specify frequency, schedule, bowel and bladder continence status, and type of assistance. b. Tenant C1 required complete assistance with bathing, in and out of the shower, undressing and dressing, and hair washing. Hospice provided showers twice weekly. c. Tenant C1 required two-person assistance with a mechanical lift. Tenant C1 required assistance with bed mobility and staff interventions with turning and positioning. Tenant C1's last implemented service plan dated 12/19/25 included the following goals for toileting/continence, bathing, and transfers/mobility: a. Tenant C1 received assistance with continence needs. b. Tenant C1 received assistance with bathing. c. Tenant C1 received assistance with transferring/mobility.	A 395		

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A 395	Continued From page 10 2. Record review on 2/04/26, revealed Tenant #2's last completed functional, health, and cognitive evaluations were completed on 10/17/25. The health/functional evaluation indicated Tenant #2 received the following assistance: a. Tenant #2 received assistance with bathing, partial assistance. Tenant #2 enjoyed baths and showers. Tenant #2 preferred showers twice weekly in the mornings. Tenant #2 required assistance with washing hard to reach areas. Tenant #2 did not want her hair washed as a salon completed that need. b. Tenant #2 used durable medical equipment for ambulation: a standard 2-wheeled walker for ambulation; a wheelchair for outings and long distances; grab bars and a toilet seat riser. Tenant #2 required 1-person physical transfer assistance. Tenant #2's last implemented service plan dated 10/17/25 included the following goals for bathing and transferring/ambulation: a. Tenant #2 received assistance with bathing. b. Tenant #2 received assistance with transferring and mobility. 3. Record review on 2/04/26, revealed Tenant #3's last completed functional, health, and cognitive evaluations were completed on 11/16/25. The health/functional evaluation indicated Tenant #3 received the following assistance: a. Tenant #3 received assistance with bathing,	A 395		

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A 395	Continued From page 11 partial bathing assistance from her daughter twice weekly. b. Tenant #3 received assistance with continence; partial toileting and continence assistance; scheduled toileting assistance. Staff were to encourage Tenant #3 to use her pendant for continence needs outside of the scheduled continence schedule. Tenant #3's last implemented service plan dated 11/16/25 included the following goals for bathing and continence: a. Tenant #3 received assistance with bathing. b. Tenant #3 received assistance with transferring and mobility. When interviewed on 2/04/26 at 12:24 p.m., the Care Coordinator confirmed the tenants reviewed failed to have service plans that were individualized and included all identified needs. When interviewed on 2/04/26 at 2:30 p.m., the Executive Director and the Operations Coordinator confirmed tenant service plans were not individualized and based on evaluations.	A 395		
A 405	481-69.26(4)c Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: c. The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy This REQUIREMENT is not met as evidenced	A 405		

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A 405	Continued From page 12 by: Based on interview and record review, the Program failed to identify all service providers other than the Program on the service plan for 1 out of 7 tenants reviewed (Tenant C1). Finding follows: Record review on 2/03/26, revealed Tenant C1's functional, health, and cognitive evaluations dated 12/19/25, indicated Tenant C1 received shower assistance twice weekly from hospice. Tenant C1's physician's orders, dated 11/05/25 revealed an admission order to hospice. Tenant C1's service plan dated 12/19/25 lacked any information regarding hospice services. When interviewed on 2/04/26 at 2:30 p.m., the Executive Director and the Operations Coordinator confirmed Tenant C1's 12/19/25 service plan failed to include hospice involvement.	A 405		

Plan of Correction
Story Point Cedar Falls
Previously known as Cedarstone Senior Living – AL
4715 Algonquin Drive, Cedar Falls, IA

Revisit FC# 10907
Enclosed is the required Plan of Correction regarding the recertification visit conducted from 2/2/2026 through 2/9/2026. Submission of this response of the Plan of Correction is not a legal admission that a deficiency exists, or that the Statement of Deficiencies was correctly cited, and is also not to be construed as an admission against interest by the residence, or any employees, agents or other individuals who drafted or may be discussed in the response on the Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission of agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Cited Deficiency: 481-67.2(3) The program shall follow the policies and procedures established by the program. The program failed to follow established policies for internal investigations of abuse and the reporting of suspected abuse for 1 out of 7 tenants:

- **The Corrective Actions which were accomplished for those residents who were found to have been affected by the deficient practice.**
    - Tenant #2 – currently remains in the Community. The Regional Director with the new management company, Story Point Group, met with this resident on 4/9/2026 to ensure that she has no current complaints and feels safe and well cared for.
    - The Executive Director at the time of this survey has been terminated.
- **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
    - All residents have the potential to be affected.
    - No other residents were identified during the post investigation.
- **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**
    - The Regional Director of Support and Integration conducted an in-service with all department leaders on the policy for abuse reporting and investigation process on 4/9/2026.

- **How the corrective actions will be monitored to ensure the deficient practice will not recure.**
    - Any concerns voiced by residents, family or staff will be investigated immediately. Concerns are discussed at morning stand-up meeting with Leadership staff. New Management company conducted an in service and introduced the company Morning Meeting Stand Up template which discusses resident falls, changes in condition, incidents and grievances.
    - Any deficiencies noted in internal audits will be addressed at Stand-up meeting.
- **The date by which the regulatory insufficiency will be corrected: 4/9/2026**

Cited Deficiency: 481-67.7(2)a Waiver of Criteria for Retention

- **The Corrective Actions which were accomplished for those residents who were found to have been affected by the deficient practice.**
    - Tenant C1 was discharged 1/2/2026.
- **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
    - All residents that require a retention waiver or exceed retention criteria have the potential to be affected.
    - No other residents were identified during the post investigation.
- **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**
    - The Wellness Director or her designee will review the 24-hour report in PCC as well as the shift-to-shift staff documentation at the clinical stand-up meeting and review any changes in conditions. Such conditions would be, but not limited to 2 persons assist, unmanageable incontinence and unstable condition.
    - The Wellness Director RN will ensure that she completes an evaluation when a resident has a significant change in condition.
    - New Management company conducted an in-service and introduced the company Morning Meeting Stand Up template which discusses resident falls, changes in condition, incidents and grievances.
- **How the corrective actions will be monitored to ensure the deficient practice will not recure.**
    - An ad-hoc quality meeting was held with all Wellness leaders to discuss the deficient practice.

    - Any deficiencies noted in internal audits will be addressed at Clinical Stand-up meeting in which the 24-hour report is reviewed.
- **The date by which the regulatory insufficiency will be corrected: 4/9/2026**

Cited Deficiency: 481-69.25(1)o Tenant Documents – incident reports

- **The Corrective Actions which were accomplished for those residents who were found to have been affected by the deficient practice.**
    - Tenant #6 – remains a resident of the community. This resident did not suffer any ill effects from the program not completing an incident report.
- **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
    - All residents have the potential to be affected.
    - No other residents were identified during the post investigation.
- **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**
    - The Wellness Director or her designee will review the 24-hour report on PCC as well as the shift-to-shift staff documentation at the clinical stand-up meeting that is held Monday through Friday and review any changes in condition to ensure that an incident report is entered into PCC if applicable.
    - The Wellness Director or her designee will audit the 24-hour report and shift to shift report and Incident reports Monday through Friday for 3 months.
    - New Management company has been in-serviced and introduced the company Morning Meeting Stand Up template which discusses resident falls, changes in condition, incidents and grievances.
- **How the corrective actions will be monitored to ensure the deficient practice will not recure.**
    - An ad-hoc quality meeting was held with all Wellness leaders to discuss the deficient practice.
    - Any deficiencies noted in internal audits will be addressed at Clinical Stand-up meeting in which the 24-hour report is reviewed.
    - New Management company has been in-serviced and introduced the company Morning Meeting Stand Up template which discusses resident falls, changes in condition, incidents and grievances.
- **The date by which the regulatory insufficiency will be corrected: 4/9/2026**

Cited Deficiency: 481-69.26(1) Service Plans – a service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2)

- **The Corrective Actions which were accomplished for those residents who were found to have been affected by the deficient practice.**
    - Tenant C1 was discharged 1/2/2026.
- **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
    - All residents have the potential to be affected.
    - No other residents were identified during the post investigation.
- **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**
    - As directed by the change in Management Company, the Wellness Director and her designee have been directed to complete new evaluations and service plans on all current residents to ensure accuracy of level of care and ensure that all service plans are resident centered.
- **How the corrective actions will be monitored to ensure the deficient practice will not recure.**
    - An ad-hoc quality meeting was held with all Wellness leaders to discuss the deficient practice.
    - Any deficiencies noted in internal audits will be addressed at Clinical Stand-up meeting in which the 24-hour report is reviewed.
- **The date by which the regulatory insufficiency will be corrected: 5/5/2026**

Cited Deficiency: 481-69.26(4) Service Plans The service plan shall be individualized and shall indicate at a minimum.....(a). The tenant's identified needs and preferences for assistance

- **The Corrective Actions which were accomplished for those residents who were found to have been affected by the deficient practice.**
    - Tenant C1 was discharged 1/2/2026.
    - Tenant #2 service plan was updated on 4/7/2026
    - Tenant #3 Wellness evaluation and service plan was updated on 4/15/2026

- **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
    - All residents have the potential to be affected.
    - No other residents were identified during the post investigation.
- **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**
    - As directed by the change in Management Company, the Wellness Director and her designee have been directed to complete new evaluations and service plans on all current residents to ensure accuracy of level of care and ensure that all service plans are resident centered.
- **How the corrective actions will be monitored to ensure the deficient practice will not recure.**
    - An ad-hoc quality meeting was held with all Wellness leaders to discuss the deficient practice.
    - Any deficiencies noted in internal audits will be addressed at Clinical Stand-up meeting in which the 24-hour report is reviewed.
- **The date by which the regulatory insufficiency will be corrected: 5/5/2026**