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
	S0464	A. BUILDING: _____ B. WING _____	C 08/05/2025

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

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A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 5 Number of tenants with cognitive impairment: 18 Total census: 23 The following regulatory insufficiencies were cited related to Complaints #129093-C and #129343-C: ========== ========== 481-69.4(231C) Nonaccredited program-application content. An application for certification or recertification of a nonaccredited program shall include the following: 69.4(4) The policy and procedure for evaluation of each tenant. A copy of the evaluation tool or tools to be used to identify the functional, cognitive and health status of each tenant shall be included. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to maintain a policy and	A 000	See attached POC 12/26/25	

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

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A 000	Continued From page 1 procedure related to evaluations to include all required information. This potentially affected all tenants (census of 23). Findings follow: 1. Record review on 7/29/25 of a policy and procedure provided for evaluations included information related to dementia care program, dementia specific activities and elopement protocol. An additional policy and procedure related to Care-Based Assessment and Individualized Service plans was also provided. It indicated the Care Based Assessment and Individualized Service plan would be maintained for each tenant. It would be completed at move in, with change in condition, semiannually and as required. Continued record review revealed the policies and procedures for evaluations did not identify all tools used to evaluate cognitive, health and functional status of each tenant. 2. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all policies and procedures requested were provided. ========== 231C.5 Written occupancy agreement required. 2. An assisted living program occupancy agreement shall clearly describe the rights and responsibilities of the tenant and the program. The occupancy agreement shall also include but is not limited to inclusion of all of the following	A 000		

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A 000	Continued From page 2 information in the body of the agreement or in the supporting documents and attachments: a. A description of all fees, charges, and rates describing tenancy and basic services covered, and any additional and optional services and their related costs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to include a description of all fees and charges. This pertained to 1 of 1 tenant reviewed charged with extra communication (Tenant #2) and potentially affected all tenants (census of 23). Findings follow: 1. Record review on 7/23/25 and 7/24/25 of Tenant #2's file revealed a Comprehensive Evaluation Agreement dated 4/18/25 indicated Tenant #2 or Tenant #2's responsible party required or requested in person or remote meeting outside of the usual service plan meetings not related to an emergency or change in condition. The evaluation gave a total points of 174. The agreement did not indicate the points that were added for the family communication. Continued record review of Tenant #2's Resident Agreement for Community signed on indicated the services provided would be based on the tenant's pre-screening and assessment and developed into a service plan. After move-in the assessment would be updated 30 days after move in and annually. Care Fees were the associated fees for the service plan based on the point system. The care fees were billed at $16.00 per point. The occupancy agreement did	A 000		

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not indicate the corresponding points for each task. It provided the dollar amount per point and that the cares fees would associated with the service plan; however, there was no disclosure of individual tasks the associated points.

A CBA training guide was provided when the surveyor requested a description of the points associated with each task. The guide indicated it was expected there would be frequent communication the week of move in and when the tenant was getting acclimated and upon changes in condition. If daily or frequent communication was required except pertaining to move-in or change in condition, then letter B or letter C would be appropriate. Letter B pertained to routine in person meetings or remote meetings outside of usual service plan meetings not related to a change in condition. Letter C pertained to daily or frequent emails outside of usual service plan meetings not related to a change in condition. The guide reflected it would 12 points for letter B and C.

Further record review revealed email communications between the Executive Director and Tenant #2's power of attorney (POA). An email from Tenant #2's POA to the Executive Director on 4/28/25 indicated the POA asked for clarification regarding what was excessive communication. The POA indicated it was not a fair charge for communication when the majority of the time it was related to billing errors or confusing statements and to follow up with Tenant #2's care. On 6/2/25 the POA emailed to request the excessive communication fee from May be removed due to continued medication errors. The POA indicated he/she felt penalized for communication of errors that should have

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been identified by staff. It was also noted she requested guidance on standard versus excessive communication and had not received the requested guidance.

When interviewed on 8/4/25 at 1:58 p.m. the Executive Director said nursing completed the assessment and it indicated the charges. A care plan meeting was offered. During the conversation the Executive Director will go over the financial aspect. The total increase (overall) in points was discussed; however, the individual listed service points (each task) were not disclosed. She said assisted living was $15.00 per point and memory care was $16.00 per point.

In summary, the occupancy agreement did not include fees and charges as required as the individual points for each task were not provided in the occupancy agreement or addendums. Tenant #2 had a signed occupancy agreement that did not disclose points for each task. A task was added on the Comprehensive Evaluation Agreement for family communication; however, the occupancy agreement not clearly define the frequency of the communication or provide the points that the task would be charged if applied.

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231C.5 Written occupancy agreement required. An assisted living program occupancy agreement shall clearly describe the rights and responsibilities of the tenant and the program. The occupancy agreement shall also include but is not limited to inclusion of all of the following

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A 000	Continued From page 5 information in the body of the agreement or in the supporting documents and attachments. i. The internal appeals process provided relative to an involuntary transfer This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide an internal appeals process related to involuntary transfer in the occupancy agreement or attachments. This pertained to 1 of 1 tenant reviewed that received 30-day notices (Tenant #1) and potentially affected all tenants (census of 23). Findings follow: 1. Record review on 7/23/25 of Tenant #1's file revealed the Residency Agreement for Community (occupancy agreement) was signed on 2/19/25. The agreement indicated a written 30-day notice of the involuntary transfer would be provided. The tenant or legal representative had the right to appeal the involuntary transfer. If the Program sought to discharge and the tenant disagreed the tenant had a right to file a grievance and request a review of discharge per 69.24(1) and the Program's Internal Appeals Process "set forth in detail in the Resident Handbook." Continued record review of the Resident Handbook revealed a general Grievance Procedure; however, an internal appeals process related to involuntary transfer was not found in the handbook as referenced in the signed agreement.	A 000		

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A 000	Continued From page 6 Further record review revealed three 30-day notices were sent regarding Tenant #1's need to transfer. The notices provided included: -The first letter was dated 6/9/25 and was sent express overnight delivery. It was sent to the Office of the Long-Term Care Ombudsman and Tenant #1's legal representative. It indicated it was formal notice of discharge from the Program and cited administrative code 481-58.40(3) and indicated it was regarding discharge of a tenant for protecting the welfare of others. It should be noted this a nursing facility regulation and did not apply to assisted living programs. It indicated the discharge was effective 30 days from the letter (7/9/25). It indicated the decision could be appealed. A hearing could be requested within 7 days of the notice. It indicated to contact the Administrator at the Department of Inspections and Appeals and the Lucas State Office Building and number were provided. It should be noted appeals process listed was not correct. The Program was required to have an internal appeals process (see for more information). -The second letter was dated 7/17/25 and was sent via certified mail, return receipt requested, copy via regular mail and via express overnight. It was sent to the Office of the Long-Term Care Ombudsman and Tenant #1's legal representative. The letter indicated pursuant to section 21 in the occupancy agreement the agreement was being terminated due to not retaining a tenant who had behaviors that have a likelihood of serious harm to self or others. It indicated to arrange for alternative housing by 8/17/25. -The third letter was dated 7/23/25 and was sent	A 000		

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express overnight. It was sent to the Office of the Long-Term Care Ombudsman and Tenant #1's legal representative. The letter cited administrative rules 69.23 and included all admission and retention criteria listed in the rules. It also listed administrative rules 69.23(2) which pertained to additional occupancy and transfer criteria, 69.23(3) which pertained to assistance with transfer from the program, 69.24 regarding involuntary transfer. The letter appeared to recite all of the administrative rules in 69.23 and 69.24, including those that did not apply to Tenant #1 and his proposed transfer. It also indicated additional disruptive behavior or continued safety concerns would result in an emergency discharge. It indicated discharge was effective 30 days from the receipt of the letter.

2. When interviewed on 7/29/25 at approximately 2:40 p.m. and 8/4/25 at 1:58 p.m. the Executive Director confirmed an internal appeals process was not found. She said the 30-day notices for Tenant #1 were on hold waiting for the internal appeals process to be developed.

In summary, a signed occupancy agreement referenced to find the internal appeals process related to involuntary transfer that was provided in detail in the handbook. Upon review a general grievance process was listed but nothing was included related to involuntary transfer. Tenant #1 received three 30 day notices for transfer and none reflected the Program's internal appeals process and the notices had incorrect information related to hearings with the Department. The occupancy agreement (or attachments) did not include an internal appeals process as required.

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A 125	481-67.2(1)d Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: d. The incident report shall include statements from individuals, if any, who witnessed the incident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop policy and procedure to include all required information regarding incident reports. This potentially affected all tenants (census of 23). Findings follow: 1. Record review on 7/21/25 of the Program's policy and procedure related to incident reports failed to include the requirement that the incident report would include statements from individuals who witnessed the incident. It should be noted there were other items not included in the policy and procedure for incident reports; however, this rule was selected as an example of one requirement that was not in policy and procedure. 2. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all policies and procedures requested were provided	A 125		
A 150	481-67.2(3) Program Policies and Procedures	A 150		

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A 150	Continued From page 9 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 procedures related to medications with pertained to and falls, which pertained to 2 of 4 tenants reviewed (Tenant #1 and Tenant #4). Findings follow: 1. Record review on 7/23/25 of Tenant #1's file revealed several falls that involved head strikes including the following: \ -An incident report dated 4/15/25 indicated staff reported Tenant #1 was walking into the dining room and grabbed a chair and lost his balance. He fell straight back and landed on his buttocks and hit his head on the floor on the dining room. Tenant #1 declined to go with EMS. He was not taken to the hospital. -An incident report dated 5/18/25 indicated staff helped Tenant #1 into the whirlpool. He needed stand by assistance so staff waited as he exited the whirlpool. When he reached down to get his towel, he asked for help in getting the towel and started to fall to the floor. The left side of the top of his head made contact with floor and started bleeding. EMS were called and he was not taken to the hospital. He had a laceration on the top of his scalp. -An incident report dated 5/22/25 indicated Augi (fall monitoring device) alert went off and he was found on the floor on his left side. He fell and hit	A 150		

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his head. He had swelling above his right eye and bruising had started on his right eye. He said he fell forward on his face. EMS was contacted due to the head strike. He said he did not want help and did not want to be taken to the hospital.

Continued record review revealed the Program's Fall Prevention and Management policy and procedure indicated if head trauma was involved or suspected, EMS should be contacted for further assessment. If EMS determined or the tenant's physician ordered the tenant would be transport to the hospital. If a licensed nurse was present a head to toe assessment would be completed. If a licensed nurse was not on duty the Wellness Director would be contacted. If the tenant remained in the building post incident staff would complete checks every 30 minutes for the first two hours then every two hours to complete a 24 hour period. Non-clinical staff would use the Incident Observation Tool to complete the checks during the 24 hour period.

When the Incident Observation Tool was requested by the surveyor, tools titled "15 Minute Checks" and "30 Minute Checks" was provided. It noted behavior/activity, signature and time.

Further record review revealed Tenant #1 had three falls with head strikes, including some with injury. The incident reports indicated Tenant #1 was not sent out to the hospital. There were no Incident Observation Tools or 30 Minute Checks tools completed related to these falls.

When interviewed on 8/5/25 at 1:23 p.m. the Wellness Director indicated EMS evaluated if there was a fall with head strike. Post fall staff

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A 150	Continued From page 11 check every two hours for 24 period. In summary, the Program did not follow the Fall Prevention and Management policy and procedure, as Tenant #1 had several falls with head strikes and did not go to the hospital. The Incident Observation Tool was not initiated related to these falls. Additionally, the Program provided two forms for 15 and 30 minutes that were provided as the tool indicated above and those were also not completed related to falls with head strikes. 2. Record review on 7/24/25 of Tenant #4's file revealed the June and July 2025 medication administration records (MARs) reflected an order for Melatonin 1 milligram (mg) gummy, 4 gummies by mouth at bedtime as needed. In June 2025 it was documented as administered 4 times, including one time it charted as not effective. The MAR did not reflect a reflect a reason for the as needed medication to be administered. Continued record review of the Program's policy and procedure for medications indicated an order was required to administer any as needed medication. It would include the name of the tenant, the specific symptoms that indicated the use of the medication, the number of hours between doses. Further record review revealed the Program did not follow the medication administration policy as there was not indicated reason or specific symptoms regarding the use of the as needed medication.	A 150		

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A 150	Continued From page 12 3. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all orders and MARs requested were provided for the tenants reviewed.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to provide adequate and appropriate services for 1 of 4 tenants reviewed (Tenant #1). Findings follow: 1. When observed on 7/28/25 at 11: 31 a.m. Tenant #1's apartment's living area floor had visible debris. The bathroom floor was not clean and was sticky when walked on. There were spots/stains observed on the floor. The toilet was heavily soiled, including the seat and bowl. It appeared to be a dark colored substance on the toilet. The shower floor also did not appear clean. Overall observations of the apartment were that it was not clean, including the living area and bathroom floors, toilet and shower floor. 2. Record review revealed Tenant #1's Resident	A 160		

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A 160	Continued From page 13 Agreement for Community dated 2/19/25 indicated basic services would be provided including weekly housekeeping. The agreement was signed by Tenant #1's responsible party and a community representative on 2/19/25. Continued record review revealed housekeeping records with dates from May, June and July failed to reflect a documented apartment clean for Tenant #1's apartment. Further record review revealed dates of employment for the prior housekeeping staff were 2/14/25 to 6/4/25. There were currently one full time housekeeper and one part time housekeeper for the memory care and assisted living buildings. 3. When interviewed on 7/28/25 at 10:10 a.m. Staff (KR) said there was currently only one full time housekeeper. She said the care staff would pick up shifts to clean. There was also a part time housekeeper. She said the apartments get cleaned but it might not be on the scheduled days. They emptied garbage, swept, vacuumed, mopped floors, cleaned the counter tops, sinks and mirrors. She said it was hard with one staff and it was hard to get back there (memory care). Cleaning of the apartments occurred on Friday or she would come in on her day off. She said she tried to log the cleaning to keep her supervisor updated. She said it was put into Tells and how much time was spent in each apartment and the size of the apartment. 4. Record review of Tenant #1's service plan reflected the goal was that his housekeeping needs would be met. Tenant #1's task log reflected for housekeeping to assist with	A 160		

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A 160	Continued From page 14 apartment tidiness as needed. There was one documented entry for April, May, June and July regarding apartment tidiness completed on 7/22/25. 5. When interviewed on 8/4/25 at 1:58 the Executive Director confirmed all housekeeping records were provided. In summary, Tenant #1 did not receive adequate and appropriate services related to housekeeping. In the signed occupancy agreement it was indicated that weekly housekeeping would be included in basic services. Observation of his apartment revealed the apartment did not appear clean, including his bathroom. His service plan did not reflect the frequency of housekeeping serviced to be provided and the task records indicated to tidy his apartment as needed. Task sheets reflected from April to July his apartment was documented that staff tidy his apartment. Housekeeping documentation did not reflect documented of an apartment clean for him and records were provided for dates in May, June and July.	A 160		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.	A 285		

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A 285	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer medications as ordered. This pertained to 3 of 4 tenants reviewed (Tenants #1, #2 and #4). Findings follow: 1. Record review on 7/23/25 of Tenant #1's file revealed the April 2025 medication administration record (MAR) reflected an order for melatonin 5 milligram (mg), two tablets by mouth at bedtime. The medication was not administered as ordered three times in April due to the medication not being available to administer. The May 2025 MAR reflected an order for Omeprazole magnesium DR 20 mg, one capsule by mouth daily before breakfast. The medication was not administered as ordered 12 times in May due to the medication not being available to administer. The June and July 2025 MARs reflected an order for Carboxymethylcellulose sodium 0.5% eye drops, 1 drop into affected eye(s) three times per day. The medication was not administered greater than 50 times due to the medication not being available to administer. 2. Record review on 7/23/25 and 7/24/25 of Tenant #2's file revealed Progress Notes indicated the following: -On 6/27/24 a fax was sent to the primary care provider (PCP) to get an order for a urinalysis	A 285		

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A 285	Continued From page 16 (UA) per family request. -On 7/6/24 Tenant #2's power of attorney (POA) called regarding concerns about a follow up to a UA sample. The POA expressed concerns of the time for the results and indicated worsening confusion was noted. A fax was received earlier in the week and a return fax was received from the PCP to start Keflex if symptomatic of a urinary tract infection (UTI). -On 7/7/24 a fax was received on 7/2/24 to start Keflex 500 mg, three times daily for 7 days. A call was placed to a local pharmacy and they could fill it by 11:00 a.m. Continued record review revealed the July 2024 MAR reflected an order for Keflex 500 mg, three times per day for 7 days. It was started on 7/7/24 and was completed on 7/14/24. The medication was ordered on 7/2/24 and was not started until 7/7/24. Further record review revealed an order was received on 1/30/25 for terconazole 80 mg vaginal suppository nightly for 14 days. It was not noted until 2/17/25. On 2/19/25 an order was received to discontinue the vaginal suppository and start Diflucan 150 mg, once now and once again in 5 days. The February 2025 MAR reflected the order for terconazole 80 mg vaginal suppository for 14 days was started on 2/17/25 and was discontinued on 2/21/25. It was only documented as administered once on 2/18/25. The other entries were charted as other, medication not available or hospitalized. The MAR reflected Diflucan 150 mg, take one tablet by mouth daily for one dose was charted on 2/22/25 as not administered due to being	A 285		

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A 285	Continued From page 17 hospitalized. Continued record review revealed orders were dated 5/27/25 for the following: -Discontinue doxycycline nightly. -Cephalexin 250 mg, one capsule by mouth nightly for six months. Further record review revealed the May and June 2025 MARs reflected the following: -The May 2025 MAR reflected the order for cephalexin 250 mg, one capsule by mouth at bedtime. It was documented as administered on 5/28/25 to 5/31/25. The May 2025 MAR also reflected doxycycline was documented as administered from during this timeframe despite being discontinued on 5/27/25 when cephalexin was ordered. -The June 2025 MAR reflected the order for cephalexin 250 mg, one capsule by mouth at bedtime. It was documented as administered on daily in June including on 6/1/25. The June MAR also reflected doxycycline was documented as administered on 6/1/25 despite being discontinued on 5/27/25 when cephalexin was ordered. 3. Record review on 7/24/25 of Tenant #4's file revealed the March and April 2025 MARs reflected an order for Fluticasone 1 dose daily in the morning. It was not administered 15 times in March and April due to not being available to administer.	A 285		

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A 285	Continued From page 18 4. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all MARs requested were provided for the tenants reviewed.	A 285		
A 106	231C.5 1 Occupancy Agreement 231C.5 Written occupancy agreement required. 1. An assisted living program shall not operate in this state unless a written occupancy agreement, as prescribed in subsection 2, is executed between the assisted living program and each tenant or the tenant's legal representative, prior to the tenant's occupancy, and unless the assisted living program operates in accordance with the terms of the occupancy agreement. The assisted living program shall deliver to the tenant or the tenant's legal representative a complete copy of the occupancy agreement and all supporting documents and attachments and shall deliver, at least thirty days prior to any changes, a written copy of changes to the occupancy agreement if any changes to the copy originally delivered are subsequently made. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to execute a signed occupancy agreement upon tenant admission. This pertained to 1 of 1 tenant reviewed admitted in the past three months (Tenant #3). Findings follow: 1. Record review on 7/24/25 of Tenant #3's file revealed admission from the general population to the memory care unit (separate certifications). A new occupancy agreement was not signed	A 106		

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A 106	Continued From page 19 when Tenant #3 was admitted to the memory care unit. Continued record review revealed the current Resident Agreement For Community was effective 2/21/25 for her apartment in the general population and was set to expire on 11/1/25. 2. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all occupancy agreements were provided for the tenants reviewed.	A 106		
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 1 of 1 tenant reviewed admitted in the three months (Tenant #3). Findings follow: 1. Record review on 7/24/25 of Tenant #3's file revealed admission to memory care on 6/19/25. A Comprehensive Resident Evaluation was dated 6/19/25. Evaluations were not completed within 30 days of admission to the memory care unit.	A 140		

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A 140	Continued From page 20 2. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all service plans 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. 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 1 of 4 tenants reviewed (Tenant #1). Findings follow: 1. Record review on 7/23/25 of Tenant #1's file revealed Progress Notes indicated the following: -On 5/15/25 Tenant #1 was escorted out by police and ambulance. -On 5/17/25 staff called the nurse to report	A 145		

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A 145	Continued From page 21 Tenant #1 was yelling and had disruptive behaviors. Staff called emergency medical services (EMS) due to disruptive behaviors. He refused transport to the hospital. -On 5/23/25 Tenant #1 was taken to the emergency department (ED). He refused to go to the ED on 7/22/25. He was transported back, upon entering the main entrance he refused to enter the building and pushed staff. He walked away from the building and refused to come in. A call was made to 911 to assistance. He argued with EMS and police outside for an hour and refused to come inside. After an hour police were able to escort him back into the memory care unit. -On 5/23/25 a call was placed to the hospital to explain new behaviors and refusal to return. The regional nurse had expressed concerns of him as a safety risk to himself and others. The ED staff said he was appropriate to return to the ED that time. Non-emergent transport was arranged and a one to one caregiver to ensure tenant safety. -On 5/31/25 staff observed Tenant #1 spilled salt down another tenant. The other tenant stood up and confronted Tenant #1 and they started to yell at each other. Staff stood between them and had Tenant #1 go to his apartment. Tenant #1 claimed he would beat up the other tenant. -On 6/26/26 an ambulance arrived to the memory care to transport another tenant to the ED. Tenant #1 attempted to exit seek through the doorway. Staff stepped in to redirect him and he pushed staff and told her to get out of his way. EMS was called per policy and he had already gone back to his apartment and had calmed	A 145		

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A 145	Continued From page 22 down. Continued record review revealed After Visit Summaries (AVS) from the ED were provided including the following: -On 5/15/25 Tenant #1 was seen in the ED for a psychiatric evaluation. -On 5/23/25 Tenant #1 was seen in the ED for a mental health problem. When interviewed on 8/5/25 at 1:23 p.m. the Wellness Director said Tenant #1's behaviors had gotten better and said he had one to one supervision through a staffing agency. Continued record review revealed a cognitive evaluation was completed on Comprehensive Resident Evaluation was completed on 5/23/25. Evaluations were not completed as needed prior to and after 5/23/25 related to behavior as noted above. 2. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all evaluations requested were provided for the tenants reviewed.	A 145		
A 220	481-69.24(1)b Involuntary Transfer from Program 69.24(1) Program initiation of transfer. If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply:	A 220		

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A 220	Continued From page 23 b. The program shall immediately provide to the office of long-term care ombudsman, by certified mail, a copy of the notification and notify the tenant's treating physician, if any. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to notify a tenant's treating physician related to involuntary transfer. This pertained to 1 of 1 tenant had received a 30 day written notice for transfer (Tenant #1). Findings follow: 1. Record review on 7/23/25 of Tenant #1's file revealed Progress Notes indicated the following: -On 5/15/25 it was noted Tenant #1 was escorted out by police and ambulance. -On 5/17/25 it was noted staff called the nurse to report Tenant #1 was yelling and had disruptive behaviors. Staff called emergency medical services (EMS) due to disruptive behaviors. He refused transport to the hospital. -On 5/23/25 it was noted Tenant #1 was taken to the emergency department (ED). He refused to go to the ED on 7/22/25. He was transported back, upon entering the main entrance he refused to enter the building and pushed staff. He walked away from the building and refused to come in. A call was made to 911 to assistance. He argued with EMS and police outside for an hour and refused to come inside. After an hour police were able to escort him back into the memory care unit.	A 220		

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A 220	Continued From page 24 -On 5/23/25 it was a call was placed to the hospital to explain new behaviors and refusal to return. The regional nurse had expressed concerns of him as a safety risk to himself and others. The ED staff said he was appropriate to return to the ED that time. Non-emergent transport was arranged and a one to one caregiver to ensure tenant safety. -On 5/31/25 it was noted staff observed Tenant #1 spilled salt down another tenant. The other tenant stood up and confronted Tenant #1 and they started to yell at each other. Staff stood between them and had Tenant #1 go to his apartment. Tenant #1 claimed he would beat up the other tenant. -On 6/26/26 it was noted an ambulance arrived to the memory care to transport another tenant to the ED. Tenant #1 attempted to exit seek through the doorway. Staff stepped in to redirect him and he pushed staff and told her to get out of his way. EMS was called per policy and he had already gone back to his apartment and had calmed down. Continued record review revealed After Visit Summaries (AVS) from the ED were provided including the following: -On 5/15/25 it was noted Tenant #1 was seen in the ED for a psychiatric evaluation. -On 5/23/25 it was noted Tenant #1 was seen in the ED for a mental health problem. When interviewed on 8/5/25 at 1:23 p.m. the Wellness Director said Tenant #1's behaviors had	A 220		

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A 220	Continued From page 25 gotten better and said he had one to one supervision through a staffing agency. 2. Further record review revealed three 30-day notices were sent regarding Tenant #1's need to transfer. The notices provided included: -The first letter was dated 6/9/25 and was sent express overnight delivery. The notice was sent to the Office of the Long-Term Care Ombudsman and Tenant #1's legal representative. It indicated it was formal notice of discharge from the Program and cited administrative code 481-58.40(3) and indicated it was regarding discharge of a tenant for protecting the welfare of others. It should be noted this a nursing facility regulation and did not apply to assisted living programs. It indicated the discharge was effective 30 days from the letter (7/9/25). It indicated the decision could be appealed. A hearing could be requested within 7 days of the notice. It indicated to contact the Administrator at the Department of Inspections and Appeals and the Lucas State Office Building and number were provided. It should be noted appeals process listed was not correct. The Program was required to have an internal appeals process (see for more information). -The second letter was dated 7/17/25 and was sent via certified mail, return receipt requested, copy via regular mail and via express overnight. It was sent to the Office of the Long-Term Care Ombudsman and Tenant #1's legal representative. The letter indicated pursuant to section 21 in the occupancy agreement the agreement was being terminated due to not retaining a tenant who had behaviors that have a likelihood of serious harm to self or others. It	A 220		

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A 220	Continued From page 26	A 220		

indicated to arrange for alternative housing by 8/17/25.

-The third letter was dated 7/23/25 and was sent express overnight. It was sent to the Office of the Long-Term Care Ombudsman and Tenant #1's legal representative. The letter cited administrative rules 69.23 and included all admission and retention criteria listed in the rules. It also listed administrative rules 69.23(2) which pertained to additional occupancy and transfer criteria, 69.23(3) which pertained to assistance with transfer from the program, 69.24 regarding involuntary transfer. The letter appeared to recite all of the administrative rules in 69.23 and 69.24, including those that did not apply to Tenant #1 and his proposed transfer. It also indicated additional disruptive behavior or continued safety concerns would result in an emergency discharge. It indicated discharge was effective 30 days from the receipt of the letter.

Continued record review revealed Tenant #1's file lacked any documentation regarding the notification of Tenant #1's primary care provider (PCP).

When interviewed on 8/5/25 at 1:23 p.m. the Wellness Director said she did not know if Tenant #1's PCP was notified of the 30-day notice.

When interviewed on 7/29/25 at approximately 2:40 p.m. and 8/4/25 at 1:58 p.m. the Executive Director confirmed an internal appeals process was not found. She said the 30-day notices for Tenant #1 were on hold waiting for the internal appeals process to be developed.

In summary, three 30-day discharge notices were

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A 220	Continued From page 27 sent in June and July and all three notices had incorrect information provided related to agency contact information, incorrect administrative rule information related to transfer/discharge, incorrect appeals information, and Tenant #1's file lacked notification of the PCP of the 30 day discharge notice.	A 220		
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' 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 3 of 4 tenants reviewed (Tenants #1, #2, and #3). Findings follow: 1. Record review on 7/23/25 of Tenant #1's file revealed Progress Notes indicated the following: -On 5/15/25 it was noted Tenant #1 was escorted out by police and ambulance. -On 5/23/25 it was noted Tenant #1 was taken to the emergency department (ED). He refused to go to the ED on 7/22/25. He was transported back, upon entering the main entrance he	A 290		

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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 290	Continued From page 28 refused to enter the building and pushed staff. He walked away from the building and refused to come in. A call was made to 911 to assistance. He argued with EMS and police outside for an hour and refused to come inside. After an hour police were able to escort him back into the memory care unit. -On 5/23/25 it was a call was placed to the hospital to explain new behaviors and refusal to return. The regional nurse had expressed concerns of him as a safety risk to himself and others. The ED staff said he was appropriate to return to the ED that time. Non-emergent transport was arranged and a one to one caregiver to ensure tenant safety. Continued record review revealed After Visit Summaries (AVS) from the ED were provided including the following: -On 5/15/25 it was noted Tenant #1 was seen in the ED for a psychiatric evaluation. -On 5/23/25 it was noted Tenant #1 was seen in the ED for a mental health problem. Further record review revealed nurse's notes were not documented by exception including the reason Tenant #1 was escorted out by police and ambulance on 5/15/25 and when he returned to the building. Nurse's notes were also not documented when Tenant #1 returned back from the second ED visit on 5/23/25. 2. Record review on 7/23/25 and 7/24/25 of Tenant #2's file revealed Progress Notes indicated on 4/25/25 a new order was received to	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0464	A. BUILDING: _____ B. WING _____	C 08/05/2025

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

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A 290	Continued From page 29 start cephalexin 500 milligram (mg), take one capsule by mouth, three times daily for seven days for a urinary tract infection (UTI). A nurse's note was not completed after the antibiotics were completed to follow up on any further signs and symptoms of a UTI. 3. Record review on 7/24/25 of Tenant #3's file revealed Tenant #3 moved from the general population to the memory care unit on 6/19/25. The units are certified separately. A nurse's note was not completed with her admission to the memory care unit. 4. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all nurse's notes for the tenants reviewed were provided.	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 as required. This pertained to 1 of 4 tenants reviewed (Tenant #1). Findings follow: 1. Record review on 7/23/25 of Tenant #1's file	A 320		

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A 320	Continued From page 30 revealed Progress Notes indicated the following: -On 5/15/25 Tenant #1 was escorted out by police and ambulance. -On 5/17/25 staff called the nurse to report Tenant #1 was yelling and had disruptive behaviors. Staff called emergency medical services (EMS) due to disruptive behaviors. He refused transport to the hospital. -On 5/23/25 Tenant #1 was taken to the emergency department (ED). He refused to go to the ED on 7/22/25. He was transported back, upon entering the main entrance he refused to enter the building and pushed staff. He walked away from the building and refused to come in. A call was made to 911 to assistance. He argued with EMS and police outside for an hour and refused to come inside. After an hour police were able to escort him back into the memory care unit. -On 5/23/25 a call was placed to the hospital to explain new behaviors and refusal to return. The regional nurse had expressed concerns of him as a safety risk to himself and others. The ED staff said he was appropriate to return to the ED that time. Non-emergent transport was arranged and a one to one caregiver to ensure tenant safety. -On 5/31/25 staff observed Tenant #1 spilled salt down another tenant. The other tenant stood up and confronted Tenant #1 and they started to yell at each other. Staff stood between them and had Tenant #1 go to his apartment. Tenant #1 claimed he would beat up the other tenant. -On 6/26/26 an ambulance arrived to the memory	A 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 320	Continued From page 31 care to transport another tenant to the ED. Tenant #1 attempted to exit seek through the doorway. Staff stepped in to redirect him and he pushed staff and told her to get out of his way. EMS was called per policy and he had already gone back to his apartment and had calmed down. Continued record review revealed there were no incident reports provided related to the incidents noted above. 2. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all incident reports 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 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed and failed to have service plans reflect the needs of the tenants. This pertained to 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow:	A 350		

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A 350	Continued From page 32 1. Record review on 7/23/25 of Tenant #1's file revealed Progress Notes indicated the following: -On 3/3/25 Tenant #1 was working towards established with a Veterans Affairs (VA) clinic for a new primary care provider (PCP). His family planned to switch his medications to the VA pharmacy once care was established. -On 5/15/25 Tenant #1 was escorted out by police and ambulance. -On 5/17/25 staff called the nurse to report Tenant #1 was yelling and had disruptive behaviors. Staff called emergency medical services (EMS) due to disruptive behaviors. He refused transport to the hospital. -On 5/23/25 Tenant #1 was taken to the emergency department (ED). He refused to go to the ED on 7/22/25. He was transported back, upon entering the main entrance he refused to enter the building and pushed staff. He walked away from the building and refused to come in. A call was made to 911 to assistance. He argued with EMS and police outside for an hour and refused to come inside. After an hour police were able to escort him back into the memory care unit. -On 5/23/25 a call was placed to the hospital to explain new behaviors and refusal to return. The regional nurse had expressed concerns of him as a safety risk to himself and others. The ED staff said he was appropriate to return to the ED that time. Non-emergent transport was arranged and a one to one caregiver to ensure tenant safety.	A 350		

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A 350	Continued From page 33 -On 5/31/25 staff observed Tenant #1 spilled salt down another tenant. The other tenant stood up and confronted Tenant #1 and they started to yell at each other. Staff stood between them and had Tenant #1 go to his apartment. Tenant #1 claimed he would beat up the other tenant. -On 6/26/26 an ambulance arrived to the memory care to transport another tenant to the ED. Tenant #1 attempted to exit seek through the doorway. Staff stepped in to redirect him and he pushed staff and told her to get out of his way. EMS was called per policy and he had already gone back to his apartment and had calmed down. Continued record review revealed After Visit Summaries (AVS) from the ED were provided including the following: -On 5/15/25 Tenant #1 was seen in the ED for a psychiatric evaluation. -On 5/23/25 Tenant #1 was seen in the ED for a mental health problem. When interviewed on 8/5/25 at 1:23 p.m. the Wellness Director said Tenant #1's behaviors had gotten better and said he had one to one supervision through a staffing agency. Further record review revealed a 30-day notice dated 7/17/25 indicated the Program was not able to retain a tenant who had exhibited behaviors that have a likelihood of serious harm to self or others. On 5/31/25 he went up to another tenant and poured salt over the tenant's head. He had a significant change where he was exit seeking, was not able to be redirected and	A 350		

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A 350	Continued From page 34 eloped. He also had three falls and refused treatment per guidelines. On 6/26/25 it was noted Tenant #1 pushed a staff member. Continued record review revealed a Order Summary Report dated 5/6/25 indicated Tenant #1 used the Program's pharmacy. A date could not be found in Tenant #1's file related to when the change to the VA medications and provider occurred; however, a medication list from the VA was provided dated 4/28/25. Further record review revealed the service plan dated 5/23/25 did not provide interventions related to Tenant #1's behaviors as noted above and did not reflect the one to one care. The service plan reflected staff administered his medications. Staff managed orders and medications. It also reflected Tenant #2 used the Program's pharmacy vendor. The service plan did not reflect Tenant #1's medications were through VA and the time needed to ordered medications to ensure a timely delivery. 2. Record review on 7/23/25 and 7/24/25 of Tenant #2's file revealed the July 2025 medication administration record (MAR) reflected an order for levothyroxine 50 microgram (mcg), 1 tablet by mouth once daily, on an empty stomach. It was reflected to be administered early (morning) the rest the a.m. medications were indicated at 9:00 a.m. Continued record review revealed staff administered her medications. The service plan did not reflect Tenant #2 had a medication not administered with other morning medication and was to be administered on an empty stomach.	A 350		

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A 350	Continued From page 35 3. Record review on 7/24/25 of Tenant #3's file revealed an order was received dated 6/13/25 to discontinue the continuous glucometer (Dexcom) and start blood glucose checks four times per day, before meals and at 2:00 a.m. Continued record review revealed the service plan dated 6/19/25 reflected she required diabetic management with blood glucose readings. Tenant #3 had a Dexcom, monitor blood glucose before meals and once on night shift. Further record review revealed Tenant #3's service plan was not updated as needed to reflect the discontinuation of the Dexcom and the order for blood glucose checks four times per day. 4. Record review on 7/24/25 of Tenant #4's file revealed the June and July 2025 medication administration records (MARs) reflected an order for nitroglycerin sublingual 0.4 milligram (mg), dissolve one tablet under the tongue every 5 minutes up to 3 doses for chest pain. Call 911 after 3 doses. Continued record review revealed Tenant #4's service plan reflected staff administered her medications. It also reflected she took Eliquis (anticoagulant medication) twice daily. The service plan did not Tenant #4 had an order for nitroglycerin as needed for chest pain. 5. When interviewed on 8/4/25 at 1:58 p.m. the	A 350		

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A 350	Continued From page 36 Executive Director confirmed all service plans were provided for the tenants reviewed.	A 350		
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans within 30 days of taking occupancy. This pertained to 1 of 1 tenants reviewed admitted in the last three months (Tenant #3). Findings follow: 1. Record review on 7/24/25 of Tenant #3's file revealed she was admitted to the memory care unit on 6/19/25. A service plan was developed dated 6/19/25. The Program failed to update the service plan within 30 days of taking occupancy. 2. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all service plans were provided for the tenants reviewed.	A 360		
A 370	481-69.26(3)a 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	A 370		

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A 370	Continued From page 37 less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain signed service plans when a change of condition occurred. This pertained to 2 of 4 tenants reviewed (Tenants #1 and #2). Findings follow: 1. Record review on 7/23/25 of Tenant #1's file revealed service plans were updated on 4/24/25, 5/22/25 and 5/23/25. None of the service plans were signed by Tenant #1 or Tenant #1's legal representative or a health or human services professional. 2. Record review on 7/23/25 and 7/24/25 of Tenant #2's file revealed a service plans were updated on 3/12/25 and 4/18/25. Neither of the service plans were signed by Tenant #2 or Tenant #2's legal representative or a health or human services professional. 3. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all service plans were provided for the tenants reviewed.	A 370		
A 410	481-69.26(4)d Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own	A 410		

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A 410	Continued From page 38 activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans to reflect planned and spontaneous activities. This pertained to 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Record review on 7/23/25 of Tenant #1's file revealed Tenant #1 had a Global Deterioration Scale (GDS) of three, which indicated mild cognitive decline. The service plan indicated he would maintain independence with socialization/activities. The service plan failed to reflect planned and spontaneous activities. 2. Record review on 7/23/25 and 7/24/25 of Tenant #2's file revealed Tenant #2 had a GDS of four, which indicated moderate cognitive decline. The service plan indicated she would receive assistance with socialization/activities. The service plan failed to reflect planned and spontaneous activities. 3. Record review on 7/24/25 of Tenant #3's file revealed Tenant #3 had a GDS of three, which indicated mild cognitive decline. The service plan reflected she was independent with socialization/activities. The service plan failed to reflect planned and spontaneous activities. 4. Record review on 7/24/25 of Tenant #4's file revealed Tenant #4 a GDS of four, which	A 410		

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A 410	Continued From page 39 indicated moderate cognitive decline. The service plan reflected she would receive assistance with socialization/activities. The service plan failed to reflect planned and spontaneous activities. 5. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all service plans were provided for the tenants reviewed.	A 410		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure all staff received eight hours of dementia education within 30 days of employment. This pertained to 5 of 5 staff reviewed. Findings follow: 1. Record review on 7/29/25 of Staff A's training documents indicated she was hired on 6/19/25 and did not have eight hours of dementia specific training completed within 30 days of hire. 2. Record review on 7/29/25 of Staff B's training documents indicated she was hired on 5/15/25 and did not have eight hours of dementia specific training completed within 30 days of hire.	A 545		

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A 545	Continued From page 40 3. Record review on 7/29/25 of Staff C's training documents indicated she was hired on 5/8/25 and did not have eight hours of dementia specific training completed within 30 days of hire. 4. Record review on 7/29/25 of Staff D's training documents indicated she was hired on 4/10/25 and did not have eight hours of dementia specific training completed within 30 days of hire. 5. Record review on 7/29/25 of Staff E's training documents indicated she was hired on 9/8/25 and did not have eight hours of dementia specific training completed within 30 days of hire. 6. When interviewed on 8/4/25 at 1:58 p.m. the Executive Director confirmed all dementia training was provided for the staff reviewed.	A 545		

OK
10/6/25

PLAN OF CORRECTION

Provider/Supplier Name:	CEDARSTONE SENIOR LIVING- Memory Care
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 000	**Correction of Cited Deficiency:** Evaluations were completed for all 23 identified residents. An updated letter outlining all fees, charges, and rates, including those for optional services, will be sent to the Responsible Party. Any optional service will be reviewed with both parties acknowledging agreement for the optional service fee. Additionally, a copy of the internal appeals process was provided. Resident #1 is being reassessed by community regarding the need for an involuntary discharge.	10/31/2025
	Assessment to Identify other Residents that may be affected: The updated letter, which includes a detailed breakdown of fees, charges, and rates (including optional services), will be sent to all residents' legal representative. A copy of the internal appeals process accompanied the letter.	10/31/2025
	Procedure to ensure on-going compliance: As part of the move-in process, the internal appeals process for involuntary transfers, along with a detailed explanation of all fees, including optional services, is reviewed with the resident during lease signing. The Executive Director or their designee will audit the charts of all new move-ins to confirm that both the service fees and appeals process have been reviewed. Prior to	10/31/2025

	an involuntary transfer being initiated, a service plan meeting will be held with Community Leadership, resident and legal responsible party to discuss reason for transfer and alternative options.	
	Monitoring for on-going compliance: ED will review audit results as part of weekly Department Head meetings for three consecutive months to ensure continued compliance.	10/10/2025
A 125	**Correction of Cited Deficiency:** Staff were re-educated on incident reports including the requirement of adding written statements from the resident involved and any individuals who witnessed the incident.	10/17/25
	Assessment to Identify other Residents that may be affected: Staff received re-education on the incident report policy, emphasizing the inclusion of statements from the resident and all witnesses in incident documentation.	10/10/2025
	Procedure to ensure on-going compliance: The Wellness Director will audit all incident reports to verify that required statements are included before the reports are signed. These audits will be conducted over a 12-week period to ensure compliance with the updated policy.	12/26/2025
	Monitoring for on-going compliance: The Executive Director will review the results of the Incident Report Audits on a weekly basis and discuss findings during the monthly Department Head Meetings for three consecutive months to ensure continued adherence to the policy.	10/31/2025
A 150	**Correction of Cited Deficiency:** Resident # 1 -fall on 8/12/25 resident allowed EMS to evaluate and take him to the hospital. Fall on 8/26/25 resident did not hit his head. Resident # 4- has not used her PRN Melatonin in August or September.	10/10/25
	Assessment to Identify other Residents that may be affected: A review of PRN medication administration was conducted, and no additional residents were identified as being affected. A community in-service is scheduled for 10/3/2025 to review policy and procedure updates related to medication administration and fall management.	10/10/2025
	Procedure to ensure on-going compliance: A community-wide in-service will be held on 10/3/2025 to educate staff on the updated policies regarding falls and medication management. The Wellness Director and Business Office Director will ensure all Wellness staff complete this training. The Wellness Director will conduct weekly spot checks of PRN medication usage for 8 weeks, with audit results reported to the Executive Director. In addition, the Wellness Director will audit incidents involving resident falls with potential head trauma to ensure post-fall monitoring is completed according to policy during the first 26 hours.	10/3/2025
	Monitoring for on-going compliance: Audit findings related to PRN medication usage and falls involving potential head trauma will be reviewed with the	10/17/2025

	Executive Director during weekly one-on-one meetings for a period of three months to ensure continued compliance**.**	
A 160	**Correction of Cited Deficiency:** Resident #1- apartment was deep cleaned. Contracted services were in to clean common areas and support cleaning apartments while new staff were hired and trained.	10/3/2025
	Assessment to Identify other Residents that may be affected: The community has hired housekeeping staff to support improved cleanliness and maintenance of resident apartments. Contract services were in to assist with housekeeping needs while new staff were trained.	10/3/2025
	Procedure to ensure on-going compliance: The Plant Operations Director or designee will perform weekly spot checks of resident apartments to verify that cleaning standards are being met consistently.	10/3/2025
	Monitoring for on-going compliance: The Plant Operations Director will review the results of these spot checks with the Executive Director during their 1;1 meeting on a weekly basis for 12 consecutive weeks to ensure continued compliance.	10/31/2025
A285	**Correction of Cited Deficiency:** A medication review was completed for Residents #1, #2, and #4 to confirm that their medications were filled in a timely manner and administered according to physician orders.	9/8/2025
	Assessment to Identify other Residents that may be affected: The Pharmacy and Wellness Director conducted an audit of all residents to ensure that medications were being filled promptly and administered as prescribed by physicians.	10/3/2025
	Procedure to ensure on-going compliance: The Wellness Director will audit all new medication orders twice a week to confirm that they are properly entered into the Medication Administration Record (MAR) and administered per physician orders. This process will continue for a period of three months.	10/10/2025
	Monitoring for on-going compliance: Wellness Director will review audit findings with the Executive Director weekly during their 1;1 meeting for three months to ensure continued compliance with medication management. Protocols.	10/10/2025
A 106	**Correction of Cited Deficiency:** Resident #3 has had a new agreement signed on 6/23/2025 related to the apartment change from AL to MC on 6/19/2025.	6/23/2025
	Assessment to Identify other Residents that may be affected: An audit was conducted on 10/1/2025 to review residents who transitioned between levels of care. All identified residents have signed updated residency agreements as required.	10/1/2025
	Procedure to ensure on-going compliance: An in-service training was provided to Department Directors to reinforce the requirement for a new residency agreement whenever a resident transitions from one level of care to another. The Executive Director or designee will audit all apartment moves to confirm that updated agreements are	10/10/2025

	completed for residents moving between levels of care.	
	Monitoring for on-going compliance: Audit findings will be reviewed and discussed during weekly Department Head Meetings for 8 consecutive weeks to ensure continued compliance.	10/10/2025
A 140	**Correction of Cited Deficiency:** Resident #3 had a 30 day evaluation completed on 8/13/2025. due to move to AL to MC.	10/1/2025
	Assessment to Identify other Residents that may be affected: An audit was conducted beginning on 10/1/2025 to review all residents who have transitioned between levels of care, ensuring that required 30-day evaluations were completed	10/10/25
	Procedure to ensure on-going compliance: The Wellness Director will audit all residents who transition from one level of care to another over a 12-week period to confirm that 30-day evaluations are completed in a timely manner.	12/26/25
	Monitoring for on-going compliance: The Wellness Director will review audit results with the Executive Director on a weekly basis for three months to ensure sustained compliance.	12/3/2025
A 145	**Correction of Cited Deficiency:** Resident #1 was scheduled for a comprehensive evaluation due to a significant change in condition from hospitalization on 8/25/2025.	8/25/2025
	Assessment to Identify other Residents that may be affected: Wellness Nurses received education regarding the requirements for completing significant change and annual evaluations.	10/10/2025
	Procedure to ensure on-going compliance: Beginning 10/1/2025, the Wellness Director and Memory Care Director will review the 24-hour report with the Executive Director to identify any residents experiencing a significant change in condition. If identified, a comprehensive evaluation will be completed. This audit process will continue for 8 weeks to ensure compliance.	10/10/2025
	Monitoring for on-going compliance: The Wellness Director will present audit results during weekly Department Head Meetings for a period of two months to support continued compliance.	12/3/2025
A 220	**Correction of Cited Deficiency:** Resident #1 continues to reside in the community.	10/1/2025
	Assessment to Identify other Residents that may be affected: At the time of the audit, no other residents were identified as being at risk for involuntary transfer.	10/1/2025
	Procedure to ensure on-going compliance: An in-service was conducted with Department Directors and Wellness Nurses to reinforce the requirement of notifying and documenting communication with the Primary Care Provider (PCP) prior to initiating any involuntary discharge notice.	8/6/2025
	Monitoring for on-going compliance: The Executive Director will review each resident's chart prior to issuing any involuntary discharge letter to confirm that proper PCP notification has occurred. If an involuntary discharge is	10/1/2025

	deemed appropriate, the matter will be reviewed and documented in the weekly Department Head meeting minutes.	
A 290	**Correction of Cited Deficiency:** Resident #1-progress notes reflect medical changes and follow up with the VA for care needs. Resident #2-progress notes reflect therapy, specialist visits, and over all care updates. Resident #3- progress notes reflect documentation to include antibiotic use, hospice notes and changes in care.	8/7/2025
	Assessment to Identify other Residents that may be affected: No additional residents were identified at this time.	10/1/2025
	Procedure to ensure on-going compliance: An in-service was conducted with staff to reinforce the requirement that progress notes must document key issues such as behavioral or mental health concerns, antibiotic use, transitions between levels of care, or any other significant events that warrant inclusion in the 24-hour report.	10/10/2025
	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.	12/3/2025
A 320	**Correction of Cited Deficiency:** Resident #1- incident report was updated via late entry in the progress notes that links to the incident report.	9/30/2025
	Assessment to Identify other Residents that may be affected: Re-education on Incident Reports was held with Wellness Nurses. No other residents identified. Policy is being followed.	10/10/2025
	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. Incident Reports will be evaluated to ensure proper documentation, including follow-up actions, is completed in accordance with policy	10/10/2025
	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.	12/26/2025
A 350	**Correction of Cited Deficiency:** Resident #1- service plan reviewed and updated Resident #2- service plan reviewed and updated Resident #3- service plan reviewed and updated Resident #4- service plan reviewed and updated	8/29/25
	Assessment to Identify other Residents that may be affected: Staff received re-education reinforcing that service plans must be updated annually and/or following any significant change in condition.	10/10/2025
	Procedure to ensure on-going compliance: The Wellness Director or designee will conduct audits of service plans following each significant change or annual assessment to ensure timely and accurate updates. Audits will be conducted over a three month period to ensure compliance.	12/3/2025

	Monitoring for on-going compliance: Audit results will be reviewed by the Wellness Director during weekly Department Head Meetings for three consecutive months to ensure continued adherence to service plan requirements.	10/10/2025
A 360	**Correction of Cited Deficiency:** Resident #3's service plan has been updated to reflect current care needs.	8/13/2025
	Assessment to Identify other Residents that may be affected: An in-service was conducted to reinforce that residents transitioning between levels of care must have their service plans updated within 30 days of the move in.	8/27/25
	Procedure to ensure on-going compliance: The Wellness Director or Memory Care Director will ensure that service plans are updated for any resident who moves from one level of care to another. An audit will be conducted to verify compliance with this requirement.	10/10/25
	Monitoring for on-going compliance: Audit results will be reviewed and discussed during the weekly Department Head Meetings for a period of three months to ensure continued compliance.	12/3/2025
A 370	**Correction of Cited Deficiency:** Resident #1 and Resident #2- The resident and/or their legal representative were offered the opportunity to attend an in person or video conference to review service plan. Attendance will be documented after meeting occurs.	10/10/2025
	Assessment to Identify other Residents that may be affected: Beginning on 10/1/2025, the resident and/or their legal representative will be offered the opportunity to attend in person, phone or video conference to review an updated service plan. Attendance or decline to the invitation will be documented on the service plan along with staff signature and date.	10/1/2025
	Procedure to ensure on-going compliance: The Executive Director, Wellness Director, or Memory Care Director will conduct a service plan review meeting with the resident and/or their legal representative following each initial, annual, or significant change assessment. All participants will provide signatures during the meeting. Meetings may be held in person, by phone, or via video conference. To ensure compliance, the Executive Director will review resident service plans for documentation of meeting and attendance on a weekly basis for a period of three months.	10/3/2025
	Monitoring for on-going compliance: Audit results will be presented by the Executive Director during the weekly Department Head Meetings for three months to ensure continued compliance.	10/3/2025
A 410	**Correction of Cited Deficiency:** MC engagement plan reviewed to enhance engagement opportunities. Resident #1-MC engagement plan updated 9/4/2025 Resident #3- MC engagement plan updated 7/25/25 Resident #4- MC engagement plan updated 6/18/25	9/4/2025

	Assessment to Identify other Residents that may be affected: The Memory Care Director reviewed each resident's Social Profile to identify shared interests and enhance engagement opportunities within the community.	10/3/2025
	Procedure to ensure on-going compliance: The Resident Services Director and Memory Care Director will meet monthly to develop and review program ideas based on residents' social profiles. Program calendars will be audited monthly to track attendance, identify successful activities, and remove those with consistently low participation. This process will be carried out over a three-month period to ensure relevance and resident engagement.	10/10/2025
	Monitoring for on-going compliance: The Resident Services Director will review the Calendar of Planned Events with the Executive Director on a monthly basis for three months to ensure continued compliance and effectiveness of programming.	10/10/2025
A 545	**Correction of Cited Deficiency:** All identified staff have completed the required 8 hours of dementia training.	10/10/2025
	Assessment to Identify other Residents that may be affected: All new employees will be scheduled to complete 8 hours of dementia training within the first 30 days of employment.	10/10/2025
	Procedure to ensure on-going compliance: The Business Office Director will monitor completion of the required dementia training for all new employees within their first four weeks of employment. Training records will be audited weekly for 3 months to ensure compliance.	10/10/2025
	Monitoring for on-going compliance: The Business Office Director will review audit findings with the Executive Director on a weekly basis for three months to ensure continued compliance with training requirements.	10/10/2025