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 10/15/2025

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. Tenants without cognitive impairment: 5 Tenants with cognitive impairment: 20 Total census: 25 The following regulatory insufficiencies were cited during the investigation of Complaint #130287-C. ========== Iowa Code 231C.5(2)a 231C.5(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 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. Based on interview and record review, the program failed to include a description of fees for one to one agency care in the occupancy agreement which applied to 1 of 2 current tenants reviewed (Tenant #1). Findings follow:	A 000		

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 Record review on 10/8/25 revealed a Resident Fee Change form for Tenant #1 dated 8/15/25 for $10,614.75 with a note: Please process this fee change to add charges for 7/21/25 - 8/2/25 for 1:1 agency care for this resident. A line asking, "How was consent obtained from resident or responsible party" had a response: N/A. Attached to the Resident Fee Change form were two itemized bills from a medical staffing agency dated 8/1/25 and 8/8/25 with hourly charges ranging from $38.00/hour to $57.00/hour. A second Resident Fee Change form dated 9/2/25 was in Tenant #1's record (with no entry under how consent was obtained for the service) with a charge for $6,847.50. Hourly charges ranged from $38.00/hour to $60.00/hour for 8/3/25 - 8/11/25. There was no Resident Fee Change form for 5/25/25 - 7/20/25. Tenant #1's responsible party signed his lease/occupancy agreement on 2/19/25. Addendum B of the lease included a section on Resident Rights. The community was required to protect and promote his rights. His rights included being fully informed of the services available and related costs. He also had the right to not provide a third party guarantee of payment. The Operations Coordinator was interviewed on 10/9/25 at 11:50 AM and reported she had a telephone call with Tenant #1's daughter/responsible party on 5/23/25 at 3:43 PM (a two minute call, based on the call log). When she called the daughter, Tenant #1 was at the hospital due to his aggression and they felt he needed 1:1 care were he to return. His daughter was on vacation and reportedly said she agreed to whatever care the program thought should be provided.	A 000		

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A 000	Continued From page 2 Tenant #1's daughter was interviewed on 10/8/25 at 12:00 PM. She reported receiving bills for nearly $80,000 for charges she did not authorize. She emailed the following information: - A screenshot of a text message on 5/23/25 at 8:17 PM to the former Executive Director. The daughter said she talked with staff at the Emergency Room (ER) and they would be sending her father back to the program. She was informed by the ER nurse program staff had to take care of her father as that was what they were paying for. She did not approve of paying for additional charges. - The former Executive Director emailed the daughter on 8/25/25 notifying her she gave verbal authorization to proceed with 1:1 care and associated costs on 5/23/25 at 3:43 PM. Due to the verbal authorization, she would be invoiced for the 1:1 caregiver services rendered. - A further email from the former Executive Director on 8/26/25 noted they offered to have the daughter set up her own private duty care or they could coordinate the service and bill it back to Tenant #1. The daughter may have forgotten this as it was an emotional time. - Tenant #1, via his daughter, received a statement dated 8/31/25 with charges for an Additional Fee - one on one Agency care (5/25 - 7/20) for $56,637.45 and (7/21 - 8/2) for $10,614.75. - He received a second statement on 9/30/25 with charges for an Additional Fee - one on one Agency care (8/3 to 8/11/25) for $6,847.50. When asked if Tenant #1 or his representative had signed a contract or were aware of the charges from the Agency when implemented, the current Executive Director, Operations	A 000		

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A 000	Continued From page 3 Coordinator and Wellness Director did not provide evidence of a contract or authorization.	A 000		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to administer medication as prescribed to 2 of 2 current tenants reviewed (Tenant #1 and Tenant #2) and 1 of 1 discharged tenant reviewed (Tenant C1). Findings follow: 1) Record review on 10/8/25 of progress notes revealed on 8/29/25 the nurse contacted Tenant #1's Primary Care Provider (PCP) to request a new prescription of Escitalopram (a medication used to treat anxiety and depression) due to having none available. The nurse explained there was a 90-day supply ordered in June, but the program did not receive the full supply. Tenant #1 had not received the medication for 2-3 weeks due to failed refill attempts. The nurse also received clarification the Vitamin B-12 order should read 1,000 mcg tablet, once daily.	A 285		

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A 285	Continued From page 4 A review of the August and September 20205 Medication Administration Records (MAR) for Tenant #1 revealed the following: - He did not receive Carboxymethycellulose Sodium, an eye drop used to treat dry eyes, as prescribed 19 days in August and 19 days in September due to it not being available. - Beginning on 8/6/25 - 8/31/25, Tenant #1 did not receive Escitalopram. - Tenant #1 did not receive his Olopatadine HCL eye drop from 8/2/25 - 8/8/25 due to it not being available. - Staff did not administer Refresh Liquigel eye drops 11 days in August or 14 days in September as it was not available. - He did not receive Omeprazole from 9/8/25 - 9/15/25. - The August MAR for Tenant #1 read Vitamin B-12 1,000 MCG, take 3 tablets by mouth daily. He only received this pill on 8/1/25, 8/9/25 and 8/28/25. It was marked not available the other days of the month. He did not receive it in September until 9/16/25. - Staff did not administer Vitamin D3 to Tenant #1 from 9/10/25 - 9/19/25. During an interview with Staff A on 10/8/25 at 3:22 PM she reported staff notified the Wellness Director when a tenant was running low on medication, especially because his pills came from the Veterans Administration (VA). The Wellness Director would then reorder the medication. She noticed they tend to run out of medication for Tenant #1, possibly because pills weren't reordered the way they should be. She mostly noticed this with his eye drops. She discussed her concerns with him not having eye drops available with the Wellness Director.	A 285		

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A 285	Continued From page 5 Staff B was interviewed on 10/9/25 at 9:50 AM and reported issues with getting Tenant #1's medication reordered from the VA, especially his eye drops, Vitamin B and Vitamin D. Staff B would tell the Wellness Director they didn't have a certain medication but said maybe he should have texted this information to ensure it was received. The program had a policy on Medication Orders - Reorder Guidelines to ensure tenant medications were ordered as required. VA medications should be ordered by the tenant or responsible party. The nurse should communicate to the tenant or responsible party regarding the need for more medication in time for the to procure another supply of medication. The Wellness Director was interviewed on 10/9/25 at 11:50 AM and reported she needed to improve on communication to ensure Tenant #1's medication was refilled and available to him. 2) Record review of progress notes on 10/9/25 revealed the following information about Tenant C1: - A skin/wound note was entered on 8/26/25 due to an ongoing ulcer to the right outer area of her foot, measuring 0.5 cm x 0.4 cm. She denied discomfort. - A skin/wound note on 8/30/25 indicated the wound on her outer right foot measure 0.8 cm x 0.8 cm and still did not cause her pain. - Tenant C1 requested Acetaminophen on 9/2/25 and 9/3/25 due to pain in her foot. The medication was effective. On 9/4/25 her family asked for the medication to be given every 6 hours. - Skin/wound notes on 9/5/25 and 9/9/25	A 285		

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identified Tenant #1's outer right foot was red and swollen. She complained of pain and had difficulty bearing weight.
- The program nurse documented a new order was received from the hospice provider for Oxycodone, 5 mg, 1 tablet three times daily as needed for moderate pain and Tramadol, 50 mg, take 1/2 tablet three times daily for pain.
- Staff documented on 9/13/25, 9/14/25 and 9/15/25 the Tramadol was not available to administer.
- A skin wound note from 9/16/25 identified the wound on the inner right foot measured 1 cm x 1.1 cm and was red and swollen. She experienced pain with touch. Scheduled Acetaminophen and Tramadol were given.
- Tenant C1's family was at the program on 9/19/25 and requested Oxycodone for her to treat the pain. She was also seen by the hospice nurse on that date who identified the foot wound continued to be red, swollen and cause her pain.

A review of orders for Tenant C1 revealed a prescription for Tramadol dated 9/8/25 at 10:53 AM and a prescription for Oxycodone 5mg dated 9/6/25 at 1:00 PM.

The September MAR for Tenant C1 noted her Tramadol was not available until the evening dose on 9/15/25. She did not receive a dose of Oxycodone to treat her pain until 9/19/25.

During an interview with Staff B on 10/9/25 at 9:50 AM he recalled there was a delay in administering Tramadol and Oxycodone to Tenant C1 after they were prescribed to manage her pain. Tenant C1 seemed to be uncomfortable. He had conversations with the tenant's family and hospice nurse about her

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experiencing pain and didn't understand why the medication wasn't available to administer.

Staff C was interviewed on 10/9/25 at 10:11 AM and stated she knew Tramadol and Oxycodone were medications which were prescribed to Tenant C1. There were times when she entered Tenant C1's room and found her grabbing her leg or foot. Tenant C1 was unable to verbally express the need for pain medication but would be grimacing which indicated she was experiencing pain. The hospice nurse directed the staff to watch for these cues and request pain medication to help her with this. Tenant C1's family also wanted her pain needs to be met. Staff C would ask the medication partners to get her pain medication but did not know if they always followed through with this when requested.

The Wellness Director was interviewed about Tenant C1's orders for Tramadol and Oxycodone on 10/9/25 at 11:50 AM. She reported she was not familiar with the situation but would provide additional information on 10/13/25. The Wellness Director did not dispute the findings as of 10/15/25.

3) Record review of an Order Summary Report signed by the PCP (Primary Care Provider) revealed Tenant #2 was to have a protein shake twice daily.

The September, 2025 MAR noted beginning on 9/11/25, staff failed to administer the protein shakes to Tenant #2 one or two times each day. In October, staff did not administer the protein shake as prescribed 7 of 8 days reviewed.

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A 285	Continued From page 8 On 10/9/25 at 11:50 PM, the Wellness Director stated in an interview Tenant #2's family provided the protein shake and was not doing so any longer. They requested the shake get discontinued, but the Wellness Director had not talked with Tenant #2's PCP to get an order to discontinue this yet.	A 285		
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: 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 the treating physician when issuing an involuntary discharge notice to 1 of 2 current tenants reviewed (Tenant #1). Findings follow: Record review on 10/9/25 revealed the program issued a formal notice of a 30-day termination of the residency agreement on 9/22/25. The notice was addressed to Tenant #1, the Department, the Office of Long-term Care Ombudsman and Tenant #1's daughter/personal representative.	A 220		

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A 220	Continued From page 9 There was no indication the tenant's treating physician was notified of the discharge. When questioned about this on 10/13/25, the interim Director and Wellness Director did not dispute these findings.	A 220		