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 02/12/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 4 Tenants with cognitive impairment: 24 Total census: 28 No regulatory insufficiencies were cited during the investigation of Complaint #130763-C. Regulatory insufficiencies were cited during the investigation of Complaint #130963-C. A revisit was completed from 8/05/25 (Complaints #129093-C and #129343-C), regulatory insufficiencies were recited.	A 000	See attached POC 4/9/26	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to follow established policies related to incident reporting for 2 of 7 tenants reviewed (Tenant #2, Tenant #5). Findings follow: 1. Record review on 2/10/26, of the Program's Communication Log revealed on 1/14/26, Tenant #2 had two open sores on her buttocks region. Record review on 2/12/26, revealed Tenant #2's file indicated an admission date of 10/01/25. A review of Tenant #2's incident reports revealed no	A 150		

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A 150	Continued From page 1 incident reports related to injuries. 2. Record review on 2/10/26, of the Program's Communication Log revealed on 1/07/26, Tenant #5 had a sore on his right forearm that appeared infected. Record review on 2/12/26, revealed Tenant #5's file indicated an admission date of 12/30/25. A review of Tenant #5's incident reports revealed no incident reports related to injuries. Record review of the Program policy, Incident Reports, dated 5/31/23, provided the following guidance: An incident report form shall be used for all accidents, injuries, or incidents involving residents, staff, and visitors and shall be completed by the Wellness Nurse, or if there was no nurse on duty, by the first responder. When interviewed on 2/12/26 at 12:50 p.m., the Executive Director confirmed no incident reports were completed for Tenant #2's and Tenant #5's injuries observed by staff.	A 150		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.	A 285		

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A 285	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to follow physician's orders for 1 out of 7 tenants (Tenant #4). Finding follows: Record review on 2/12/26, revealed Tenant #4's file revealed the following medication orders dated 11/19/25: a.) Alprazolam 0.25 milligrams(mg) tablet taken three times daily. b.) Amlodipine Besylate 5 mg tablet taken once daily. c.) Aspirin 81 mg chewable tablet taken once daily. d.) Atorvastatin 20 mg tablet taken once daily. e.) Buspirone HCL 15 mg tablet taken twice daily. f.) Donepezil HCL 5 mg tablet taken once daily. g.) Fluoxetine HCL 20 mg capsule taken once daily. h.) Gabapentin 300 mg capsule taken twice daily. i.) Levetiracetam 500 mg tablet taken twice daily. j.) Lidocaine HCL 4% (percent) cream applied twice daily to lower back. k.) Memantine HCL 10 mg tablet taken twice daily. l.) Mirtazapine 15 mg tablet taken once daily. m.) Potassium CL ER 10 MEQ tablet once daily. n.) Risperidone 0.25 mg tablet taken twice daily. o.) Senna Plus tablet taken twice daily. p.) Trazodone 50 mg, 1.5 tablets taken daily. Continued record review revealed Tenant #4's November 2025 Medication Administration Record (MAR) reflected on 11/19/25, Tenant #4's ordered medication for twice a day failed to be administered until the afternoon of 11/21/25. The MAR also reflected on 11/19/25, Tenant #4's once	A 285		

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A 285	Continued From page 3 daily medications were not administered until 11/22/25. When interviewed on 2/12/26 at 12:50 p.m., the Executive Director confirmed there was a gap between the time the medications for Tenant #4 were ordered and the time she actually began taking them. The Executive Director indicated the Program used a pharmacy based out of Missouri and the medications were shipped by Fed Ex.	A 285		
A 315	481-67.7(2)a Waiver of Criteria for Retention 67.7(2) Waiver petition procedures. The following procedures shall be used to request and to receive approval of a waiver from criteria for the retention of a tenant: a. A program shall submit the waiver request on a form and in a manner designated by the department as soon as it becomes apparent that a tenant exceeds retention criteria pursuant to an evaluation by a health care or human service professional. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the Program failed to obtain a waiver of the criteria of retention for 1 of 1 tenant reviewed who exceeded the Program's level of care criteria (Tenant #2). Finding follows: Record review on 2/12/26, revealed Tenant #2's file indicated an admission date of 10/01/25 with a diagnosis of dementia, hypertension,	A 315		

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A 315	Continued From page 4	A 315		

gastroesophageal reflux disease, spinal stenosis, osteoarthritis, pain, nutritional deficiency, underweight, and generalized anxiety disorder. Tenant #2's last completed evaluations on 1/20/26, revealed Tenant #2's assessed needs as: required two-person transfers with a gait belt, received physical assistance with bathing, received medication administration assistance, required physical assist for evacuation, could not reposition herself in bed due to weakness, required complete assistance with eating, hand fed meals and provided verbal cues to chew/swallow/drink, and was on hospice.

When interviewed on 2/03/26 at 9:46 a.m., the Wellness Nurse Manager indicated Tenant #2 was on hospice. The Wellness Nurse Manager reported Tenant #2 required two-person transfer assistance shortly before Christmas 2025 due to a fall. The Wellness Nurse Manager indicated Tenant #2 was bed bound for the past few weeks. Tenant #2 was no longer toileted or transferred. The staff regularly checked on and provided incontinence care instead of toileting. Hospice provided bathing.

When interviewed on 2/03/26 at 10:33 a.m., the Memory Care Director indicated Tenant #2 stayed in bed now and had not transferred for the last several weeks. The Memory Care Director reported staff regularly checked on Tenant #2 and provided incontinence care. The Memory Care Director added Tenant #2 required two staff for incontinence care.

When interviewed on 2/11/26 at 10:01 a.m., Staff C reported Tenant #2 was bed bound for the past several weeks and was on comfort care due to her in the end of life stages.

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A 315	Continued From page 5 When interviewed on 2/12/26 at 12:50 p.m., the Executive Director confirmed no waiver of the criteria of retention was requested for Tenant #2. The Executive Director indicated she reached out to the Department on 2/12/26 regarding a waiver for Tenant #2.	A 315		
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 with significant change for 1 out of 7 tenants reviewed (Tenant #2). Finding follows: Record review on 2/12/26, revealed Tenant #2's most recent evaluations were completed on 1/20/26. Tenant #2's evaluations identified the following assessed needs:	A 145		

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A 145	Continued From page 6 a. Staff assisted Tenant #2 to the toilet using a gait belt. A bedside commode was used. b. Staff provided complete grooming assistance. c. Staff bathed Tenant #2. Staff assisted Tenant #2 in and out of the shower/bath. Staff were to wash most of her body. Staff completed this task two times a week. d. Staff fully dressed Tenant #2. e. Staff hand fed Tenant #2. Staff provided cues to chew, swallow, drink. f. Staff used two-person transfers with a gait belt. g. Staff turned and repositioned Tenant #2 when in bed due to weakness. When interviewed on 2/03/26 at 9:46 a.m., the Wellness Nurse Manager indicated Tenant #2 was on hospice. The Wellness Nurse Manager reported Tenant #2 required two-person transfer assistance shortly before Christmas 2025 due to a fall. The Wellness Nurse Manager indicated Tenant #2 was bed bound for the past few weeks. Tenant #2 was no longer toileted or transferred. The staff regularly checked on and provided incontinence care instead of toileting. Hospice provided bathing. When interviewed on 2/03/26 at 10:33 a.m., the Memory Care Director indicated Tenant #2 stayed in bed now and had not transferred for the last several weeks. The Memory Care Director reported staff regularly checked on Tenant #2 and provided incontinence care. The Memory Care Director added Tenant #2 required two staff for incontinence care. When interviewed on 2/11/26 at 10:01 a.m., Staff C reported Tenant #2 was bed bound for the past several weeks and was on comfort care due to her in the end of life stages. .	A 145		

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A 145	Continued From page 7 When interviewed on 2/12/26 at 12:50 p.m., the Executive Director confirmed no evaluations were completed when Tenant #2 stopped transferring out of her bed and was nearing the end stages of her disease so that the service plan could be updated.	A 145		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to develop the service plan based off of evaluations and update the plan as needed for 2 out of 7 tenants reviewed (Tenant #3, Tenant #4). Findings follow: 1. Record review on 2/12/26, revealed Tenant #3's last completed functional, health, and cognitive evaluations were completed on 9/04/25. The health/functional evaluation indicated Tenant #3 required the following assistance from staff: a. Tenant #3 required assistance with bathing. Staff were to wash hard to reach areas, wash hair once a week, provide partial assistance, and	A 350		

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A 350	Continued From page 8	A 350		

provide cues.
b. Tenant #3 required assistance with eating. Staff were to provide hand-free stand-by assistance. Ideally, staff were to sit next to Tenant #3 to ensure safety.

Tenant #3's last implemented service plan dated 9/04/25 identified the following:
a. Tenant #3 received assistance with bathing.
b. Tenant #3 ate appropriately.

2. Record review on 2/12/26, revealed Tenant #4's last completed functional, health, and cognitive evaluations were completed on 1/06/26. The health/functional evaluation indicated Tenant #4 required the following assistance from staff:

a. Tenant #4 required complete assistance with continence. Staff were to assist with Tenant #4's clothing if soiled, wiping, and incontinence cares.
b. Tenant #4 required complete assistance with bathing which included full washing and assistance with clothing.
c. Tenant #4 required complete assistance with dressing on all items of clothing.
d. Tenant #4 required stand by assistance with meals.
e. Tenant #4 required one-person physical assistance using a gait belt for transfers.

Tenant #4's last implemented service plan dated 1/06/26 identified the following:
a. Tenant #4 received assistance with continence.
b. Tenant #4 received assistance with bathing.
c. Tenant #4 dressed appropriately.
d. Tenant #4 ate appropriately.
e. Tenant #4 received assistance with transfers.

When interviewed on 2/12/26 at 12:50 p.m., the Executive Director confirmed the service plans for

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A 350	Continued From page 9 Tenant #3 and Tenant #4 were not updated to reflect the evaluations completed.	A 350		
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 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 include a list of person-centered and spontaneous activities based on the tenant's abilities and personal interests for tenants who are unable to plan their own activities, including tenants with dementia for 2 out of 7 tenants (Tenant #3, Tenant #4). Findings follow: 1. Record review on 2/12/26, revealed Tenant #3's file indicated an admission date of 6/20/25 with a diagnosis of dementia. Tenant #3's last implemented service plan, dated 9/04/25, indicated Tenant #3 received assistance with socialization, activities, and spirituality. The service plan failed to include a list of person-centered and spontaneous activities based on the tenant's abilities and personal interests. 2. Record review on 2/12/26, revealed Tenant #4's file indicated an admission date of 11/14/25	A 410		

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A 410	Continued From page 10 with a diagnosis of dementia. Tenant #4's last implemented service plan, dated 1/06/26, indicated Tenant #4 received assistance with socialization, activities, and spirituality. The service plan failed to include a list of person-centered and spontaneous activities based on the tenant's abilities and personal interests. When interviewed on 2/12/26 at 12:50 p.m., the Executive Director confirmed Tenant #3's and Tenant #4's service plans failed to include a list of person-centered and spontaneous activities based on the tenant's abilities and personal interests.	A 410		

ok

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

Enclosed is the required Plan of Correction regarding the recertification visit conducted from 2/2/2026 through 2/12/2026. Submission of this response of the Plan of Correction is not a legal admission that a deficiency exists, or that the Statement of Deficiencies was correctly cited, and is also not to be construed as an admission against interest by the residence, or any employees, agents or other individuals who drafted or may be discussed in the response on the Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission of agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Cited Deficiency: 481-67.2(3) The program shall follow the policies and procedures established by the program. The program failed to follow established policies related to incident reporting.

- **The Corrective Actions which were accomplished for those residents who were found to have been affected by the deficient practice.**
    - Tenant #2 – Resident is no longer at the community. Discharge date 3/13/2026.
    - Tenant #5 – Head to toe Skin assessment completed on 4/7/2026 and there are no alterations in skin with no open areas noted.
- **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
    - All residents have the potential to be affected.
    - No other residents were identified during the post investigation.
- **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**
    - The Wellness Director or her designee will review the 24-hour report on PCC as well as the shift-to-shift staff documentation at the clinical stand-up meeting that is held Monday through Friday and review any changes in condition or incidents to ensure that an incident report is entered into PCC if applicable.
    - The Wellness Director or her designee will audit the 24-hour report and shift to shift report and Incident reports Monday through Friday for 3 months.
- **How the corrective actions will be monitored to ensure the deficient practice will not recure.**

    - An ad hoc quality meeting was held with all Wellness leaders to discuss the deficient practice and plan of correction was reviewed with the leaders with the Regional Wellness Director.
    - Any deficiencies noted in internal audits will be addressed at Clinical Stand-up meeting in which the 24-hour report is reviewed.
- **The date by which the regulatory insufficiency will be corrected: 4/9/2026**

Cited Deficiency: 481-67.5(2) Medications

Each program shall follow its own written medication policy……

- **The Corrective Actions which were accomplished for those residents who were found to have been affected by the deficient practice.**
    - Tenant #4 – Resident did not suffer any adverse effects from the delay in medication.
    - Wellness leadership has been trained by new ownership on running a missed medication report in PCC to identify any missed medications.
- **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
    - All residents have the potential to be affected.
    - No other residents were identified during the post investigation.
- **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**
    - The Wellness Director or her designee will review the 24-hour report in PCC as well as the shift-to-shift staff documentation and run a missed medication report in PCC at the clinical stand-up meeting.
- **How the corrective actions will be monitored to ensure the deficient practice will not recure.**
    - An ad hoc quality meeting was held with all Wellness leaders to discuss the deficient practice and plan of correction was reviewed with the leaders with the Regional Wellness Director.
    - Wellness Director or her designee will run a daily missed medication report daily for 3 months.
    - Any deficiencies noted in internal audits will be addressed at Clinical Stand-up meeting in which the 24-hour report is reviewed.
- **The date by which the regulatory insufficiency will be corrected: 4/9/2026**

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

a. **A program shall submit the waiver request on a form and in a manner designated by the department as soon as it becomes apparent that a tenant exceeds retention criteria pursuant to an evaluation by a health care or human service professional.**

- **The Corrective Actions which were accomplished for those residents who were found to have been affected by the deficient practice.**
    - Tenant #2 - Resident is no longer in the community. Discharge date 3/13/2026.
- **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
    - All residents that require a retention waiver or exceed retention have the potential to be affected.
    - No other residents were identified during the post investigation.
- **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**
    - The Wellness Director or her designee will review the 24-hour report in PCC as well as the shift-to-shift staff documentation at the clinical stand-up meeting and review any changes in conditions. Such conditions would be, but not limited to 2 person assist, unmanageable incontinence and unstable condition.
    - The Wellness Director or her designee will verify the Executive Director is aware of the need for a waiver and then verify the waiver request is submitted to the department as soon as it becomes apparent.
- **How the corrective actions will be monitored to ensure the deficient practice will not recure.**
    - An ad hoc quality meeting was held with all Wellness leaders to discuss the deficient practice and plan of correction was reviewed with the leaders with the Regional Wellness Director.
    - Any deficiencies noted in internal audits will be addressed at Clinical Stand-up meeting in which the 24-hour report is reviewed.
- **The date by which the regulatory insufficiency will be corrected: 4/9/2026**

Cited Deficiency: 481-69.22(3) Evaluation of Tenant

- **The Corrective Actions which were accomplished for those residents who were found to have been affected by the deficient practice.**

    - Tenant #2 - Resident is no longer in the community. Discharge date 3/13/2026.
- **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
    - All residents have the potential to be affected.
    - No other residents were identified during the post investigation.
- **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**
    - The Wellness Director or her designee will review the 24-hour report in PCC as well as the shift-to-shift staff documentation at the clinical stand-up meeting and review any changes in conditions. Such conditions would be, but not limited to 2 persons assist, unmanageable incontinence and unstable condition.
    - The Wellness Director RN will ensure that she completes an evaluation when a resident has a significant change in condition.
- **How the corrective actions will be monitored to ensure the deficient practice will not recure.**
    - An ad-hoc quality meeting was held with all Wellness leaders to discuss the deficient practice.
    - Any deficiencies noted in internal audits will be addressed at Clinical Stand-up meeting in which the 24-hour report is reviewed.
- **The date by which the regulatory insufficiency will be corrected: 4/9/2026**

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

- **The Corrective Actions which were accomplished for those residents who were found to have been affected by the deficient practice.**

    - Tenant #3 – Updated Wellness evaluation and service plan was completed on 4/14/2026
    - Tenant #4 – Updated Wellness evaluation and service plan was completed on 4/9/2026
- **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
    - All residents have the potential to be affected.
    - No other residents were identified during the post investigation.
- **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**
    - As directed by the change in Management Company, the Wellness Director and her designee have been directed to complete new evaluations and service plans on all current residents to ensure accuracy of level of care and ensure that all service plans are resident centered.
- **How the corrective actions will be monitored to ensure the deficient practice will not recure.**
    - An ad-hoc quality meeting was held with all Wellness leaders to discuss the deficient practice.
    - Any deficiencies noted in internal audits will be addressed at Clinical Stand-up meeting in which the 24-hour report is reviewed.
- **The date by which the regulatory insufficiency will be corrected: 5/5/2026**

Cited Deficiency: 481-69.26(4)d Service Plans - The service plan shall be individualized and shall indicate, at a minimum: (d) For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests.

- **The Corrective Actions which were accomplished for those residents who were found to have been affected by the deficient practice.**

    - Tenant #3 – Updated Wellness evaluation and service plan was completed on 4/14/2026
    - Tenant #4 – Updated Wellness evaluation and service plan was completed on 4/9/2026
- **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**
    - All residents have the potential to be affected.
    - No other residents were identified during the post investigation.
- **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**
    - As directed by the change in Management Company, the Wellness Director and her designee have been directed to complete new evaluations and service plans on all current residents to ensure accuracy of level of care and ensure that all service plans are resident centered.
- **How the corrective actions will be monitored to ensure the deficient practice will not recure.**
    - An ad-hoc quality meeting was held with all Wellness leaders to discuss the deficient practice.
    - Any deficiencies noted in internal audits will be addressed at Clinical Stand-up meeting in which the 24-hour report is reviewed.
- **The date by which the regulatory insufficiency will be corrected: 5/5/2026**