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
	S0482	A. BUILDING: _____ B. WING _____	C 04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPPERWOOD AT PRAIRIE TRAIL	2855 SW VINTAGE PARKWAY ANKENY, IA 50023

(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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 66 Tenants with cognitive impairment: 4 Total census: 70 The following regulatory insufficiencies were cited during the investigation of Complaints #131112-C and #131307-C.	A 000	See attached POC 5/1/26	
A 116	481-67.2(2) Program Policies and Procedures 67.2(2) 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 policy regarding "Fall Prevention Management" for 1 of 3 tenants reviewed (Tenant #C2), with the potential to affect other tenants who resided at the Program. Findings follow: Record review on 3/30/26 revealed Tenant #C2 admitted to the Program on 1/5/26 with diagnoses which included (but not limited to) lymphedema, pancytopenia, chronic kidney disease, chronic obstructive pulmonary disease, hyperlipemia, essential (primary) hypertension, hyperparathyroidism, diastolic (congestive) heart failure, thrombocytopenia, and atherosclerotic heart disease. Tenant #C2 was transferred to the hospital on 2/13/26, before transferring to a hospice house on 2/16/26, and eventually passed away on 2/23/26.	A 116		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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A 116	Continued From page 1 An incident report, dated 1/7/26, time stamped at 2015 (8:15 p.m.), revealed Tenant #C2 experienced a fall within her apartment, with no apparent injury. Review of the documentation post-incident reflected no evaluation completed by a licensed nurse after the fall. A review of the Post-Incident Observation notes documented by the Program's Qualified Medication Aides (QMAs), indicated a post-incident observation note had been completed for the day shift on this date: -1/8/26 at 1411 (2:11 p.m.) -1/9/26 at 1050 (10:50 a.m.) -1/10/26 at 1409 (2:09 p.m.) Review of the Program's policy, "Fall Prevention Management", reviewed date of 12/8/25, indicated under evaluations the residents were evaluated by the license nurse with the Morse Fall Scale (MFS) in Point Click Care (PCC) upon admission, quarterly and as needed. The policy indicated a comprehensive fall prevention care plan was developed by the interdisciplinary team (IDT) based on the MFS results; identified environmental concerns; input from the resident; family and support staff; resident medical conditions; and review of the fall prevention care plan. The policy directed to determine if an injury occurred and provided treatment as necessary. The policy directed to determine what caused or contributed to the fall and address the factors for the fall. The policy indicated to revise the plan of care and/or the community practices as needed. The policy also indicated re-education of staff, residents, and families as needed. Further review indicated a post fall evaluation needed completed by a licensed nurse. The resident's responsible party and physician were notified of the fall and	A 116		

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A 116	Continued From page 2 physician orders were implemented. The policy indicated the licensed nurse or medication aide completed a follow-up note every shift for three days using the post-incident progress note in PCC. During an interview on 3/31/26 at 2:45 p.m. about the procedural steps of the policy, the Director of Resident Services acknowledged the Post-Incident Observation note had been used as the post-fall evaluation with the task completed by the QMAS. The Director of Resident Services indicated the post-incident note could be done either as a QMA Post-Incident Observation note or a 72-hr general progress notes and believed the task of the actual post-fall evaluation could be delegated to the QMAs, and was unaware of the expectation the QMA Observation notes were to be completed once every shift for three days. During follow-up interview with the Executive Director (ED) on 4/1/26 at 2:07 p.m., the ED indicated Program staff were good about calling the nurse on-call about tenant falls, but acknowledged the procedural steps were not completed in accordance with the Program's established policy. During exit on 4/6/26 at 9:30 a.m., the Executive Director and Wellness Director confirmed the above findings.	A 116		
A 152	481-67.5(2)e(3) Medications 481-67.5(231B,231C,231D) Medications. 67.5(2)?Each program shall follow its own written medication policy, including the following:	A 152		

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A 152	Continued From page 3 e. When medications are administered traditionally by the program: (3) Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or PA. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to administer medications as prescribed for 1 of 3 tenants reviewed (Tenant #1). Finding follows: Record review between 3/30/26 and 4/1/26 revealed Tenant #1 admitted to the Program on 6/28/25. An assessment dated 7/24/25, as well as a service plan dated 7/29/25, both revealed Tenant #1 required assistance with medication administration from the Program's staff, with the service plan goal identified as, "Will be supported to take all medications safely and as ordered." An email communication from the family/legal representative of Tenant #1 dated 12/23/25 alerted and questioned the Program on why Tenant #1 ran out of her isosorbide medication as Tenant #1's pharmacy informed the family the medication was being filled too soon. A medication error incident report dated 12/23/25 noted "Resident has been getting higher dosage of her isosorbide medication than prescribed. She is to get 0.5 tablet by mouth (15mg of 30mg (milligram)). Meds were intended to last 60 days instead of 30. Pill is to be cut in half." An interview on 4/1/26 at 10:15 a.m. with a	A 152		

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A 152	Continued From page 4	A 152		

pharmacist at Tenant #1's providing pharmacy confirmed an order date of 11/17/25, with a 60-day supply being sent out by delivery on 11/18/25, and confirmed the isosorbide medication was sent out in 30 mg tablet form and stated a 30mg dose was the most common extended-release tablet dose, as a 15 mg dose tablet was not a product that was offered, and further confirmed the pharmacy does not provide pill-splitting service for the isosorbide medication.

A review of Tenant #1's Medication Administration Record (MAR) for November 2025 confirmed an order for Isosorbide Mononitrate Extended-Release oral tablet, 30mg with the instructions to "give 0.5 tablet by mouth in the morning".

Upon review of the documentation, it was determined Tenant #1 had been administered a 30mg dose of Isosorbide, rather than the 15mg dose prescribed starting on or around 11/18/25 and continuing until on or around 12/23/25.

Review of the Program's competency delegation form for "Medication Administration in AL" included a procedure for medication preparation to check the medication and MAR three times. The delegation form indicated to follow the six rights for medication administration, which included resident, medication, dose, time, route, and documentation.

During an interview on 3/30/26 at 4:40 p.m. with the Wellness Director and the Executive Director, the Wellness Director acknowledged the medication error from 12/23/25 and explained Tenant #1 originally was with the Program's preferred pharmacy, then Tenant #1's family/legal representative opted to change to another

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A 152	Continued From page 5 pharmacy provider of their choice and felt this was when the tablet form change occurred. The Executive Director indicated the Wellness Director notified Tenant #1's nurse practitioner (through a contracted provider) to alert her of the error, and the nurse practitioner recommended Tenant #1 remain on the 30 mg dosage due to Tenant #1's health issues, but Tenant #1's family/legal representative declined and then cancelled all services with the contracted nurse practitioner. The Executive Director reported once the concern was identified between Tenant #1's family/legal representative and confirmed by the Program. The Program initiated steps to resolve the concern including monitoring of Tenant #1, splitting the isosorbide medication upon arrival, and providing further instruction/education to Program staff. The Executive Director indicated the local Ombudsman also reviewed the medication error concern. During exit on 4/6/26 at 9:30 a.m., the Executive Director and Wellness Director confirmed the above findings.	A 152		
A 330	481-69.25(1)q Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs)	A 330		

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A 330	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure accurate documentation of health-related care tasks for 1 of 3 tenants reviewed (Tenant #1). Finding follows: Record review between 3/30/26 and 4/1/26 revealed Tenant #1 admitted to the Program on 6/28/25. A progress note dated 2/9/26 included a notation "Angiogram 2.11.26". A review of the Medication Administration Record (MAR) for February, 2026 noted the following health-related care task with a start date of 2/11/26: "Resident had an angiogram 2.11.26. Call (number deleted for privacy) if oozing or blood at groin site, fever 101 or greater, increasing pain at site, site becomes red, draining pus or foul-smelling drainage. This could be a sign of infection. Wound Care: Right groin, keep site clean & dry for 24 hrs(hours). May remove the dressing after 24 hrs & shower. Pat incision dry. Apply band aid daily until healed". The task had a discontinue date of 2/17/26. The MAR reflected the following documentation: -2/12/26 through 2/17/26 the day shift marked the treatment completed. -2/11/26 through 2/16/26 the evening shift marked the treatment completed. -2/11/26, 2/15/26, and 2/16/26 the night shift marked the treatment completed. -2/12/26, 2/13/26, and 2/14/26 no documentation was marked. A sample of staff interviews conducted on 4/1/26 in comparison with the documentation on the February 2026 MAR revealed:	A 330		

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A 330	Continued From page 7 1. When interviewed at 3:07 p.m., Staff A worked the day shift on 2/16/26 and 2/17/26 and documented the health-related task as completed. When interviewed, Staff A recalled taking Tenant #1's temperature, but stated Tenant #1 "didn't ever really even let me look at her groin, she would refuse that for me." When questioned as to why Staff A didn't document the task as a tenant refusal, Staff A stated "I don't know why it's showing documented. We had a lot going on back then." When interviewed, if Staff A ever checked the incision site, Staff A stated "I never actually looked at it." 2. When interviewed at 3:12 p.m. Staff B worked the evening shift on 2/12/26 and documented the health-related task as completed. When interviewed, Staff B stated she was "not having a clear image of it. I think I asked her, but I don't think she showed me it." When interviewed as to why Staff B didn't document the tenant refusal, Staff B stated "I don't know". During an interview on 4/1/26 at 3:20 p.m. with the Wellness Director, the Wellness Director indicated the expectation for charting/documentation if a tenant refused medication or treatment would be to use the charting code "2". The Wellness Director confirmed that although the MAR charting code of "2" indicated "drug refused", the same code should be used to also indicate when a tenant refused a treatment. During exit on 4/6/26 at 9:30 a.m., the Executive Director and Wellness Director confirmed the above findings.	A 330		

Plan of Correction
StoryPoint Ankeny
Previously known as CopperWood at Prairie Trail
2855 SW Vintage Pkwy, Ankeny, IA 50023

A116, 481-67.2(2) The program shall follow the policies and procedures established by the program.

Cited Deficiency: Based on interview and record review, the program failed to follow established policy regarding "Fall Prevention Management" for 1 of 3 tenants reviewed (Tenant #C2), with the potential to affect other tenants who resided at the program.

- **The program will correct the regulatory insufficiency by completing the following procedures:**
    - Tenant #C2 is no longer in the community
    - All post fall evaluations will be completed by a licensed nurse

- **Measures taken to ensure the problem to does not recur include:**
    - New Management company has been in-serviced and introduced the company Morning Meeting Stand Up template which discusses resident falls, changes in condition, incidents and grievances.
    - Any deficiencies noted in internal audits will be addressed at Clinical Stand-up meeting in which the 24-hour report is reviewed.

- **The program plans to monitor performance to ensure compliance by:**
    - Fall audit to be conducted Monday-Friday by Wellness Director and/or Executive Director at morning standup.

- **The regulatory insufficiency will be corrected by:** 5/1/26

A152, 481-67.5(231B,231C,231D) Medications. Each program shall follow it's own written medication policy, including the following: e. When medications are administered traditionally by the program: (3) Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or PA.

Cited Deficiency: Based on interview and record review, the program failed to administer medications as prescribed for 1 of 3 tenants reviewed (Tenant #1).

- **The program will correct the regulatory insufficiency by completing the following procedures:**
    - Ensuring medications and treatments will be administered as prescribed by tenant's physician, ANP, or PA
    - Tenant #1 remains at the community and did not suffer any ill effects from the deficiency.

- **Measures taken to ensure the problem to does not recur include:**
    - Wellness director or designee will conduct a training for all new hires regarding the "six rights" of medication administration and have the form signed off on before being designated to work the floor.
    - Current staff will also go through a "retraining" of the "six rights" of medication administration

- **The program plans to monitor performance to ensure compliance by:**
    - Weekly audit conducted by Wellness Director and/or Executive Director to ensure all Qualified Medication Aides have been properly trained and no medication errors have occurred.
    - Wellness Director or designee will observe 3 medication passes per week for 8 weeks. Any deficiencies noted in internal audits will be addressed at Stand-up meeting and shared with Regional Wellness/Operations team.
    -
- **The regulatory insufficiency will be corrected by:** 5/1/26

A330, 481-69.25(1) Tenant Documents. Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs).

Cited Deficiency: Based on interview and record review, the program failed to ensure accurate documentation of health-related care tasks for 1 of 3 tenants reviewed (Tenant #1).

- **The program will correct the regulatory insufficiency by completing the following procedures:**
    - Accurate documentation of health-related care on task sheets
    - Tenant #1 remains at the community and did not suffer any ill effects from the deficiency.

- **Measures taken to ensure the problem to does not recur include:**
    - New Management company has provided and introduced the company policies regarding documentation. All staff including new hires will be trained in the documentation polices.

- **The program plans to monitor performance to ensure compliance by:**
    - Wellness Director or designee will audit doctor's orders 3 times weekly for 8 weeks, to ensure compliance with following physician orders. Any deficiencies noted in internal audits will be addressed at Stand-up meeting and shared with Regional Wellness/Operations team.

- **The regulatory insufficiency will be corrected by:** 5/1/26