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
	S0483	A. BUILDING: _____ B. WING _____	C 04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVIGATE MC AT COPPERWOODS AT PRAIRIE	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 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: 1 Tenants with cognitive impairment: 21 Total census: 22 The following regulatory insufficiencies were cited during the investigation of Incident #131156-I, Complaint #131306-C, and Complaint #131772-C.	A 000	see attached POC 5/12/26	
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 and procedures for "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 6/18/25 and resided in the program's Memory Care unit, until Tenant #C2 passed away on 1/13/26. An incident report dated 12/25/25, time stamped at 1315 (1:15 p.m.), revealed Tenant #C2 experienced a fall within her apartment, with no apparent injury. Review of the documentation post-incident revealed no post-fall evaluation was completed by a licensed nurse. A review of the	A 116		

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A 116	Continued From page 1 Post-Incident Observation notes documented by the program's Qualified Medication Aides (QMAs), revealed: On 12/25/25 at 2145 (9:45 p.m.) indicated a post-incident observation note completed for the overnight shift. On 12/26/25 at both 1426 (2:46 p.m.) and 1429 (2:29 p.m.) indicated a post-incident observation note completed for the day shift. On 12/30/25 at 20:56 (8:56 p.m.) indicated a post-incident observation note completed for the overnight shift. On 12/31/25 at 1922 (7:22 p.m.) indicated a post-incident observation note completed for the evening shift. No post-incident observation notes were documented for the dates of 12/27/25, 12.28/25, or 12/29/25, and with the exception of the date of 12/26/25 where two notes were entered three minutes apart, only one post-incident note was documented per day. Review of the Program's policy entitled "Fall Prevention Management," reviewed date 12/8/25, indicated tenants were evaluated by a licensed nurse using the Morse Fall Scale in Point Click Care (PCC) upon admission, quarterly and as needed. After completion of the Morse Fall Scale the Interdisciplinary Team (IDT) developed a fall prevention care plan that included environmental concerns, medical conditions, and tenant, family and support staff input. The policy further directed the action following a fall included: determining if injury occurred, providing treatment if necessary, determining the cause or what contributed to the	A 116		

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A 116	Continued From page 2	A 116		

fall, addressing factors of the fall, revise the plan of care or community practices, and the reeducation of staff, tenants or family as needed. The post fall evaluation was completed by a licensed nurse. The physician and tenant's responsible party needed to be notified and physician orders were implemented. The policy directed the licensed nurse or medication aide to complete a follow up note every shift for three days using the incident observation progress note in PCC.

When interviewed on 3/31/26 at 2:45 p.m. about the procedural steps of the policy, the Wellness Director acknowledged the Post-Incident Observation note had been used as the post-fall evaluation with the task completed by the QMAS. The Wellness Director 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 a follow-up interview on 4/1/26 at 2:07 p.m., the Executive Director (ED) indicated Program staff was 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 the Wellness Director confirmed the above findings.

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A 122	Continued From page 3	A 122		
A 122	481-67.3(2) Tenant Rights 481-67.3(231B,231C,231D) Tenant rights. All tenants have the following rights: 67.3(2)?To receive care, treatment and services that are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure adequate care, treatment, and services for 1 of 3 tenants reviewed (Tenant #C1). Finding follows: Record review on 3/26/26 revealed Tenant #C1 admitted to the Program on 3/8/25 then eventually moved to the Program's memory care unit on 12/1/25. Tenant #C1's facesheet indicated diagnoses of (but not limited to) venous insufficiency (chronic) (peripheral), acute embolism and thrombosis of unspecified deep veins of right lower extremity, unspecified dementia (severe, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety), displaced intertrochanteric fracture of left femur (initial encounter for closed fracture), other abnormalities of gait and mobility, and polyneuropathy. Tenant #C1's service plan completed 12/1/25, noted the following under the section on Mobility "(Tenant #C1) has a history of falls which puts the resident at risk if she/he ambulates unassisted. Escort resident until she becomes stronger." The Program self-identified and reported the incident on 1/6/26, and indicated Tenant #C1 experienced a fall, resulting in a hip fracture. The Program's internal investigation incident summary	A 122		

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A 122	Continued From page 4	A 122		

noted the fall incident with hip fracture and noted Tenant #C1 required "stand by assistance with ambulation". The Program's internal investigation included a statement from Staff B which noted Staff B witnessed Tenant #C1 "get up and walk away from the dining room."

During an interview with Staff A on 3/25/26 at 3:00 p.m., when asked about the assistance Program staff provided to Tenant #C1, Staff A indicated it was her understanding when Tenant #C1 first moved in to the AL side of the Program, Tenant #C1 asked for assistance on how to get back to her room after meals, but then eventually she was getting up on her own and walking fine. Staff A indicated Program staff would offer assistance and Tenant #C1 would decline. Staff A stated "we took that as allowing her to be independent" and felt Tenant #C1 was "steady on her feet."

During an interview with Staff B on 3/25/26 at 3:20 p.m., when asked about Tenant #C1's incident, Staff B confirmed she was on duty at the time of the incident. Staff B indicated she was the lead medication aide on duty and believed she was at the medication cart passing medications when she noticed Tenant #C1 got up after lunch and began to walk (unassisted) back towards her room. Staff B stated Tenant #C1 was "able to ambulate on her own." Staff B indicated when she was previously in the assisted living, Program staff walked her back to her apartment from the dining room, but once she moved to memory care, Tenant #C1's room was "just down the hallway so she caught on pretty quickly".

During an interview with Staff C on 3/25/26 at 3:40 p.m., when asked about Tenant #C1's assistance level, Staff C stated Tenant #C1 walked "all over the place" and Tenant #C1 "loved

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A 122	Continued From page 5	A 122		

her independence and was very much in the routine, and we allowed that independence." Staff C indicated she was asked to complete Tenant #C1's service plan to indicate her move to memory care, but was told by Program leadership "nothing was changing for her except for the move." Staff C stated "we were already providing all the same cares, so it was on the service plan that she was listed as escorts." Staff C indicated Tenant #C1 needed the escorts when she was in assisted living, but the memory care unit was laid out in a square and Tenant #C1 quickly learned the square. Staff C stated she was new to service plans and it was ultimately "just a miscommunication blip" and the "escorts were really a cognitive intervention when she was on the assisted living side and then didn't get removed from the service plan like they should have when she moved to memory care."

Record review on 3/30/26 revealed Tenant #C1's incident report, dated 1/5/26 at 1300 (1:00 p.m.) noted the following description: "Aide went to see if resident wanted her nails done and resident was found on floor by her kitchen area. Resident stated that the door hit her when she was trying to walk in and it pushed her to the ground. She had no head injuries, but had pain in her right hip/leg." The report further noted "Vitals were taken and nurse was notified. Two aides tried to get her up, but her pain in her right leg was too bad for her to stand. Her son was notified and EMS was contacted. She was taken by EMS to the hospital."

Review of progress notes revealed a note dated 1/2/26 noted "Called (tenant's son) to advise resident to see PCP (primary care physician.) Order to recheck venous duplex right leg ...". A note dated 1/4/26 noted "Caregivers reported

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A 122	Continued From page 6 increase confusion, lethargic, and weakness." Record review on 4/1/26 revealed an evaluation dated 7/17/25, the last evaluation on file for Tenant #C1, under line item 15, 2b confirmed Tenant #C1 required "Standby/Cues" assistance with mobility. Under "Task" noted "Mobility and Transfer Assistance - Standby assist, possible physical assist if longer distances", and was not independent with mobility. Further review on 4/02/26 of progress notes revealed a progress note dated 11/19/25 (prior to Tenant #C1's move to the memory care unit) which noted the PCP met with Tenant #C1's family and had "advised resident is declining and memory is worsening. PCP told them she would recommend MC (memory care) & Hospice as she's displaying signs of end of life with disease progression." When interviewed on 4/6/25 at 8:30 a.m., the Executive Director acknowledged the Program's internal summary of the incident and the assistance level Tenant #C1 required for ambulation per the service plan and evaluation. During exit on 4/6/26 at 9:30 a.m., the Executive Director and the Wellness Director confirmed the above findings.	A 122		
A 232	481-69.22(3) Evaluation of Tenant 481-69.22(231C) 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	A 232		

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A 232	Continued From page 7	A 232		

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.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the Program failed to complete an evaluation of a tenant due to significant change for 1 of 3 tenants reviewed (Tenant #C1). Finding follows:

Record review on 4/1/26 revealed a comprehensive evaluation had been completed for Tenant #C1 on 7/17/25. The Program provided several service plans, including a service plan completed 12/1/25, no comprehensive change of condition evaluation could be located following the 7/17/25 comprehensive evaluation which coincided with the tenant's move to the memory care unit on 12/1/25.

When asked on 4/1/26 at 4:00 p.m. whether the 7/17/25 evaluation was the last evaluation on file for Tenant #C1, the Wellness Director replied via email on 4/2/26 at 4:30 p.m. and reiterated all service plans for Tenant #C1 since July were provided and "most due to change of condition". No further evaluations were provided.

When interviewed on 4/6/25 at 8:30 a.m., the Executive Director acknowledged the last comprehensive evaluation/assessment on file for Tenant #C1 was completed 7/17/25 and acknowledged a move to memory care and a potential change in services would be considered a significant change and therefore a

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A 232	Continued From page 8 comprehensive evaluation would have been needed. The ED indicated the Program's new ownership/management built additional prompts/alerts in the electronic health record system which would help the Program's nurses recognize when evaluations were due and help maintain compliance. During exit on 4/6/26 at 9:30 a.m., the Executive Director and the Wellness Director confirmed the above findings.	A 232		
A 291	481-69.27(2)a Nurse Review 481-69.27(231C) Nurse review. 69.27(2) If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to assess and document the health status of a tenant, to make recommendations and referrals as appropriate,	A 291		

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and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status for 1 of 3 tenants reviewed (Tenant #C1). Findings follow:

Record review on 3/26/26 revealed Tenant #C1 admitted to the Program on 3/8/25 then moved to the Program's memory care unit on 12/1/25. Tenant #C1's facesheet indicated diagnoses of (but not limited to) venous insufficiency (chronic) (peripheral), acute embolism and thrombosis of unspecified deep veins of right lower extremity, unspecified dementia (severe, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety), displaced intertrochanteric fracture of left femur (initial encounter for closed fracture), other abnormalities of gait and mobility, and polyneuropathy.

An evaluation completed 7/17/25, and signed by the Wellness Director was the last comprehensive evaluation completed for Tenant #C1. The Program failed to have a quarterly 90-day nurse review by 10/17/25.

When questioned about the format of the Program's nurse reviews on 4/1/25 at 11:40 a.m., the Wellness Director stated 90-day nurse reviews for tenants were done as a narrative progress note.

Progress notes for Tenant #C1 reviewed included (but not limited to):

On 9/26/25 physical therapy services were in place and services would continue for four weeks.

On 10/20/25 the tenant was meeting therapy

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A 291	Continued From page 10 goals and both physical (PT) and occupational (OT) services would plan to discontinue next week. On 10/21/25 the tenant was discharged from OT services. While the Program additionally provided service plans for Tenant #C1 included a service plan dated 9/8/25 which indicated therapy services were in place, and an additional service plan dated 10/30/25 which indicated no therapy services, no quarterly 90-day nurse review on or around 10/17/25 was located which addressed or documented Tenant #C1's health status, recommendations and referrals as appropriate, or monitored progress relating to previous recommendations, including the eventual discontinuation of therapy services. During a follow-up interview on 4/6/25 at 8:30 a.m.,the Executive Director (ED) acknowledged the concern with nurse reviews. During exit on 4/6/26 at 9:30 a.m., the Executive Director and the Wellness Director confirmed the above findings.	A 291		

Plan of Correction
StoryPoint Ankeny ALPD
Previously known as Navigate MC at 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 and procedures for "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:** 5/12/26

A122, 481-67.3(231B,231C,231D) All tenants have the following rights: To receive care, treatment and services that are adequate and appropriate.

Cited Deficiency: Based on interview and record review, the Program failed to ensure adequate care, treatment, and services for 1 of 3 tenants reviewed (Tenant #C1).

- **The program will correct the regulatory insufficiency by completing the following procedures:**
    - Tenant #C1 is no longer in the community
    - Service plans for identified tenants were reviewed to ensure interventions were current, individualized, and accurately implemented by staff.

- **Measures taken to ensure the problem to does not recur include:**
    - Staff reeducation regarding requirement to follow current evaluations regardless of perceived tenant independence

- **The program plans to monitor performance to ensure compliance by:**
    - The Executive Director or Wellness Director will audit, at least monthly, to monitor service plan accuracy, reassessment completion, and staff compliance with supervision interventions.
    - Audit results will be reviewed through the Quality Assurance process, and additional corrective action will be implemented as needed.

- **The regulatory insufficiency will be corrected by:** 5/12/26

A232, 481-69.22(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.

Cited Deficiency: Based on interview and record review, the Program failed to complete an evaluation of a tenant due to significant change for 1 of 3 tenants reviewed (Tenant #C1).

- **The program will correct the regulatory insufficiency by completing the following procedures:**
    - Tenant #C1 is no longer in the community
    - Audit of all current tenant records
- **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.
    - All nursing and applicable staff (including the Wellness Director and Executive Director) received re-education on:
        - Iowa regulation 481-69.22(231C) requirements
        - Definition of “significant change”
        - Documentation and timing of evaluations

- **The program plans to monitor performance to ensure compliance by:**
    - The Wellness Director (or designee) will conduct monthly audits of tenant records for timely annual evaluations and evaluations following significant changes
    - Audit results will be reviewed in Quality Assurance (QA) meetings

- **The regulatory insufficiency will be corrected by:** 5/12/15

A291, 481-69.27(2) If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders.

Cited Deficiency: Based on interview and record review, the Program failed to assess and document the health status of a tenant, to make recommendations and referrals as appropriate and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status for 1 of 3 tenants reviewed (Tenant #C1).

- **The program will correct the regulatory insufficiency by completing the following procedures:**
    - Tenant #C1 is no longer in the community
    - An audit of all tenants receiving program-administered prescription medications was conducted to verify 90-day nurse reviews are completed timely

- **Measures taken to ensure the problem to does not recur include:**
    - New Management company has been in-serviced and introduced new policies and processes to ensure 90-day reviews are completed in a timely manner
    - Executive Director, Wellness Director, and relevant staff were re-educated on:
        - Requirements of regulation 69.27(2)
        - Timing (every 90 days and with significant change)
        - Required documentation elements

- **The program plans to monitor performance to ensure compliance by:**
    - Wellness Director (or designee) will verify completion of all 90-day reviews weekly

- **The regulatory insufficiency will be corrected by:** 5/12/25