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
	S0491	A. BUILDING: _____ B. WING _____	R-C 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEATHERSTONE AT HICKORY TRAIL	2450 HICKORY TRAIL IOWA CITY, IA 52245

(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 population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 49 Number of tenants with cognitive impairment: 1 Total census: 50 The following regulatory insufficiencies were written during the revisit conducted to determine progress made in correcting violations cited during the initial certification completed on 3/25/25.	{A 000}	see attached POC 8/1/25	
{A 135}	481-69.22(1) Evaluation of Tenant 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	{A 135}		

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
	S0491	A. BUILDING: _____ B. WING _____	R-C 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEATHERSTONE AT HICKORY TRAIL	2450 HICKORY TRAIL IOWA CITY, IA 52245

(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 135}	Continued From page 1 program failed to complete a thorough health evaluation prior to occupancy for 1 of 1 tenants reviewed who was admitted within the previous month (Tenant #1). Findings follow: Record review on 6/10/25 revealed Tenant #1 was admitted to the program on 5/20/25. The program nurse initiated the Iowa Assisted Living Assessment on 5/20/25 which evaluated the tenant's cognitive and functional condition. The assessment did not thoroughly evaluate her health status. During an interview on 6/10/25 at 11:50 AM the Residential Services Director confirmed the Iowa Assisted Living Assessment did not include a thorough evaluation of the tenant's health condition. She had asked the Executive Director to purchase a specific type of head to toe health assessment she'd used in the past but had not received it yet.	{A 135}		
{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 a thorough health evaluation within 30 days of occupancy for 2 of 2	{A 140}		

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
	S0491	A. BUILDING: _____ B. WING _____	R-C 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEATHERSTONE AT HICKORY TRAIL	2450 HICKORY TRAIL IOWA CITY, IA 52245

(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 140}	Continued From page 2 tenants reviewed who were admitted within the previous 2 months (Tenant #1 and Tenant #2). Findings follow: Record review on 6/10/25 revealed Tenant #1 was admitted to the program on 5/20/25. The Director of Health and Wellness completed a 30-day Iowa Assisted Living Assessment which evaluated her cognitive and functional condition on 5/30/25. The assessment did not thoroughly evaluate her health status. Tenant #2 moved to the program on 5/8/25. The Director of Health and wellness completed a 30-day Iowa Assisted Living Assessment which evaluated her cognitive and functional condition on 5/30/25. The assessment did not thoroughly evaluate her health status. During an interview on 6/10/25 at 11:50 AM the Residential Services Director confirmed the Iowa Assisted Living Assessment did not include a thorough evaluation of the tenant's health condition. She had asked the Executive Director to purchase a specific type of head to toe health assessment she'd used in the past but had not received it yet.	{A 140}		

ok
7/28/25

FEATHERSTONE
AT HICKORY HILL

July 8, 2025

Department of Investigations, Appeals and Licensing
Attn: Deb Dixon
6200 Park Avenue STE 100
Des Moines, Iowa 50321

Dear Ms. Dixon:

On behalf of FeatherStone at Hickory Hill, I respectfully submit our Plan of Correction for your approval. My response is specific to the initial certification visit that was conducted between 6/9/2025 to 6/11/2025. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of state law.

Evaluation of Resident A 135

1. Correction of Regulatory Insufficiencies

- Residents #1 has been assessed utilizing the Medical History/Physical/Functional Assessment.

2. Measures to Prevent Recurrence

- RSD and Memory Care Manager will use the above-mentioned form for the Pre-Admission, Admission, Change of Condition, and Annual Assessments.

3. Monitoring for Compliance

- RSD or designee will audit 3 charts 1-time per week for 4 weeks, then quarterly for 2 quarters to ensure the Medical History/Physical/Functional Assessment is being utilized. Audits will be reviewed during the quarterly QA meeting and any findings will be addressed.

Completion Date: August 1, 2025

Evaluation of Resident A 140

1. Correction of Regulatory Insufficiencies

- Residents #1, and #2 have been assessed utilizing the Medical History/Physical/Functional Assessment.

2. Measures to Prevent Recurrence

- RSD and Memory Care Manager will use the above-mentioned form for the Pre-Admission, Admission, Change of Condition, and Annual Assessments.

3. Monitoring for Compliance

- RSD or designee will audit the charts 1-time per week for 4 weeks, then quarterly to ensure the Briggs Medical History/Physical/Functional Assessment is being utilized. Audits will be reviewed during the quarterly QA meeting and any findings will be addressed.

Completion Date: August 1, 2025

If you have any questions regarding this correspondence, please contact me at 319-595-2270.

Sincerely,

Tracy Sherzer, Executive Director