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
	S0492	A. BUILDING: _____ B. WING _____	C 03/25/2025

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

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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. Number of tenants without cognitive impairment: 0 Number of tenants with cognitive impairment: 16 Total census: 16 The following regulatory insufficiencies were cited during the investigation of Complaints #127296-C, #126864-C and #126558-C and the initial certification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000		
A 130	481-67.2(1)e Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program's policy regarding incident reports did not contain required information. Findings follow: The program's Incident and Accident Procedure for Iowa documented any adverse event or	A 130	The Plan of Correction is attached	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 130	Continued From page 1 unusual occurrence resulting in an injury, or potential injury, to a tenant was defined as an incident or accident. According to 67.2(1)e all accidents or unusual occurrences affecting a tenant must be considered an incident regardless if there was an injury or not. An incident report must then be completed. On 3/18/25 at 3:51 PM the Executive Director confirmed the policy did not contain all required information.	A 130		
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 intrview and record review the facility failed to ensure incident reports were completed for 1 of 1 tenants reviewed with wounds of unknown origin (Tenant #7). Findings include: On 3/18/25 review of progress notes for Tenant #7 revealed the following: - He was found with a small cut on the back of his head on 3/7/25. - Tenant #7's wife came to take him to the emergency room to get a CT (computed tomography) scan due to an unwitnessed injury on 3/15/25. He got the CT scan as well as two staples to a wound on his head. No incident reports detailing these events could	A 150		

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A 150	Continued From page 2 be located. The program had an Incident and Accident Procedure Iowa in which any adverse event or unusual occurrence, resulting in an injury or potential injury to a tenant, is defined as an incident or accident. An incident report was then to be completed. On 3/18/25 at 3:51 PM the Executive Director confirmed program staff failed to write incident reports as required.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide adequate care and services to 2 of 7 tenants reviewed (Tenant #1, Tenant #7). Findings include: 1) Record review on 3/19/25 revealed Tenant #7 moved to the program on 1/27/25. He was diagnosed with Parkinson's Disease, unspecified abnormalities of gait and mobility, neurocognitive disorder with Lewy bodies and dementia. A review of incident reports and progress notes	A 160		

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A 160	Continued From page 3 revealed he experienced falls on the following dates: - Tenant #7 was found lying face down on the floor of his room on 1/28/25 at 8:40 PM. He damaged a table during the fall and had bleeding on the back of his head. His family took him to the emergency room where he was treated for a 5 cm. laceration to the back of his head. - On 2/2/25 at 11:51 PM during safety checks, staff found Tenant #7 with blood all over his head. His wife came and took him to the emergency room. Tenant #7 had a 2.5 inch laceration to the back of his scalp which was treated with staples. - Tenant #7 was found on the floor next to his recliner on 2/26/25. He reported sliding out of his recliner. - Staff heard Tenant #7 calling out for help from the sun room on 3/1/25. He reported he skidded and fell on his left side. He had a scrape to the left side of his head. - Tenant #7 was found with a small cut to the back of head on 3/7/25. - On 3/15/25, Tenant #7's wife came to take him to the emergency room to see if he needed to get a head and neck CT due to an unwitnessed injury. The CT was performed with no injury found. He got two staples to his wound. - On 3/18/25, Tenant #7 was found outside of another tenant's room in the hallway on the ground. No injuries were noted. - Tenant #7 was found on the floor in the dining room by staff after they heard a crash on 3/19/25. Tenant #7's 2/28/25 service plan noted he was able to ambulate independently without a mobility device. He had a walker should he need to use it. The plan was amended on 3/9/25 to add that staff were to ensure his room was clutter free and easy to navigate. However, there was no information there were no information as to how	A 160		

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A 160	Continued From page 4 often staff were to provide supervision checks for Tenant #7. On 3/18/25 at 3:20 PM, Staff F reported she provided extra supervision checks for Tenant #7 due to his tendency to fall, although the program RN had not directed her to do so. On 3/18/25 at 2:55 PM, Staff G stated Tenant #7 had experienced 3-4 falls and received stitches, so he liked to check on the tenant more often, although he had not been directed to do so. 2) a. On 3/17/25 review of an incident report dated 3/7/25 revealed Tenant #1 was found on the floor in front of her bed propping herself up on her left elbow. Her walker was beside her. She reported she lost her balance. Her vitals were obtained, the Interim Registered Nurse (RN) was notified and the physician was sent a faxed copy of the incident report. The program completed a 72 hour-post incident follow-up sheet, in which staff were to check her vitals each shift for 3 days. Abnormal readings were as follows: - 3/7/25 on 2nd shift: pulse 129 - 3/8/25 on 3rd shift: pulse 122 - 3/8/25 on 1st shift: pulse 121 On 3/8/25, the Licensed Practical Nurse (LPN) documented Tenant #1's heart rate was 112 and she was in A-Fib. A progress note dated 3/10/25 indicated while the RN was reviewing the 72 hour alert follow-up report, she noted Tenant #1's high pulse rate. The hospice nurse came to her door at that moment and the RN told her of the high heart rate and need for evaluation, if the tenant's family agreed.	A 160		

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A 160	Continued From page 5 The hospice nurse arranged for transportation to the hospital and notified the family. A review of Tenant #1's hospital record for 3/10/25 revealed she was a 90-year old female with a history of Parkinson's disease and Lewy body dementia and she was on hospice. She presented to the emergency department due to a high heart rate (pulse). While at the hospital, her blood pressure was 141/103 with a pulse of 103. She was noted to be tachycardic. Tenant #1 was diagnosed with atrial flutter and prescribed Cardizem ER. Tenant #1 and her family chose not to pursue a hospital admission as she would have to be discharged from hospice. She returned to the program on 3/10/25. A review of Tenant #1's pulse rates revealed between the dates of 8/26/24 and 2/1/25, her heart ranged from 51 to 98. Beginning on 3/1/25, her heart rate rose above 120 on the following dates: - 3/1/25: pulse 128 - 3/12/25: pulse 123 - 3/14/25: pulse 122 - 3/16/25: pulse 121 - 3/18/25: pulse 127 - 3/19/25: pulse 122 - 3/20/25: pulse 121 The program contacted the hospice nurse on 3/20/25 to notify her they were continuing to get occasional elevated heart rate readings since she returned from the hospital the previous week. The hospice nurse said yesterday (3/19/25) she received a heart rate of 94. She thought it appeared Tenant #1 was flipping in and out of Atrial Flutter and it might take another week for the new medication, Cardizem ER, to work. She spoke with Tenant #1's primary care provider	A 160		

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A 160	Continued From page 6 (PCP) who would meet with the tenant on that date. The program had a procedure for alert values for vital signs. It was the licensed nurse's responsibility to review the results of vital signs at the beginning of their assigned shift and any time during their assigned shift when vital signs were taken. It was the responsibility of the nurse to manually re-check the vital signs at any time such values were unusual for the tenant or were critical values, such as a resting pulse greater than 120. If a tenant had a pulse rate of 120 or higher, the health care provider should be notified immediately. On 3/19/25 at 9:15 AM, Staff E reported she filled out the incident report on 3/7/25 when Tenant #1 experienced a fall. She recalled Tenant #1 had an elevated heart rate. Staff E notified the RN about her fall and elevated vitals, but was informed it was normal for a person to have a high pulse following a fall. On 3/25/25 at 8:40 AM the LPN reported when she took Tenant #1's heart rate on 3/8/25 she noted it was irregular. She believed Tenant #1 was in A-Fib. The LPN called and left a message for the former Assistant Director of Nursing. The LPN said she only worked at the program about once a month. She could not recall if she wrote a progress note about this (she did not), but believed she should have. On 3/18/25 at 3:51 PM the RN could not recall exactly when she was notified about Tenant #1's elevated heart rate. She knew she would have addressed this condition as soon as she learned of it.	A 160		

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A 160	Continued From page 7 b. A review of incident reports from the previous 3 months revealed Tenant #1 experienced falls on the following dates: - Tenant #1 fell on 1/29/25 at 11:15 AM while trying to put her shoes on. She was found on the floor in her bathroom. She had blood coming from her fingernail area. - When staff was assisting Tenant #1 from her wheelchair to her recliner on 2/7/25 at 7:30 AM, she lost her balance and was lowered to the ground. - On 2/14/25 at 4:15 AM, staff found Tenant #1 on the floor during hourly safety checks. She fell out of bed. - Tenant #1 was walking in the hallway and fell on 2/24/25. She was ambulating with her wheelchair instead of her walker. - She was found on the floor in front of her bed on 3/7/25 after losing her balance. - On 3/14/25, Tenant #1 was heard crying in her room. She was found on her left side by her closet door with her legs tangled up around her walker. Her walker was removed from her legs. She appeared to have hit the left side of her head and reported pain. A review of Tenant #1's service plan dated 12/16/24 revealed there was no indication it was typical for her to have an elevated heart rate. The plan identified she was a fall risk due to her cognitive level. There were no recommendations for how frequently staff should check on her. On 3/18/25 at 10:45 AM, Staff E stated staff were supposed to complete safety checks on tenants every two hours. She generally checked on Tenant #1 more frequently due to her history of falling, but she was not directed to do so by the nurse.	A 160		

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A 160	Continued From page 8 On 3/18/25 at 3:20 PM, Staff F said while she was never told by a nurse to check on tenants more than hourly, she liked to check on Tenant #1 more frequently as she experienced a lot of falls. She believed tenants were to be checked on each hour. On 3/18/25 at 2:55 PM, Staff G reported he tried to check on individuals who were at a high risk for falls more often than other tenants. 3. On 3/18/25 at 9:10 AM the Director of Clinical Services reported they do not specify how often tenants should receive safety checks in their care plans. Every tenant should receive safety checks every two hours, but tenants who are a high falls risk should be checked on more frequently. On 3/25/25 at 11:15 AM the Executive Director confirmed the program failed to provide services which met the needs of tenants.	A 160		
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:	A 285		

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A 285	Continued From page 9 Based on observation, interview and record review the program failed to ensure medication was administered according to physician's orders for 2 of 3 tenants observed during a medication administration pass (Tenant #8 and Tenant #9). Findings follow: 1) During the observation of the medication pass on 3/19/24 beginning at 9:15 AM, Tenant #8 received 500 mg. of Tylenol. Staff E reported Tenant #8 was to receive 2 pills of 325 mg. Tylenol according to the Medication Administration Record (MAR), but this dose of Tylenol was not available. Staff E said she had previously informed the Interim Registered Nurse of this. A review of the Physician Order Report for Tenant #8 dated 2/18/25 revealed she was to receive Tylenol 325 mg., three times daily at 8:00 AM, noon and 4:00 PM. The Physician Order Report also directed staff to administer Ferrous Sulfate, 325mg. every morning with orange juice at 9:00 AM. Staff did not administer this pill. 2) During the medication pass on 3/19/24 starting at 9:15 AM, Tenant #9 was administered Caltrate, ursodiol, fluticasone, gabapentin and preservision Areds 2. Tenant #9 moved to the program from a Rehab facility. Discharge orders from the Rehab facility dated 2/24/25 indicated staff should also be administering Cyanocobalamin, fexofenadine, furosemide, and Metamucil. 3) On 3/20/24 at 9:10 AM, the Executive Director confirmed the tenants did not receive the medications as ordered by their physicians.	A 285		

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A 135	Continued From page 10	A 135		
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 program failed to complete a thorough health evaluation prior to occupancy for 2 of 7 tenants reviewed who were admitted over the past three months (Tenant #2 and Tenant #7). Findings follow: Tenant #2 moved to the program on 1/13/25. The program nurse completed a cognitive and functional assessment of Tenant #2's needs on 1/13/25, but did not complete a thorough evaluation of his health needs. Tenant #7 moved to the program on 1/27/25. The program nurse completed a cognitive and functional assessment of Tenant #7's needs on 1/6/25, but did not complete a thorough evaluation of his health needs.	A 135		

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A 135	Continued From page 11 On 3/18/25 at 3:51 PM the Executive Director confirmed the program did not complete a thorough health evaluation of tenants' needs.	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 7 tenants reviewed who were admitted over the past three months (Tenant #2 and Tenant #7). Findings follow: Tenant #2 moved to the program on 1/13/25. The program nurse completed a cognitive and functional assessment of Tenant #2's needs on 2/10/25, but did not complete a thorough evaluation of his health needs. Tenant #7 moved to the program on 1/27/25. The program nurse completed a cognitive and functional assessment of Tenant #7's needs on 2/28/25, but did not complete a thorough evaluation of his health needs. On 3/18/25 at 3:51 PM the Executive Director	A 140		

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A 140	Continued From page 12 confirmed the program did not complete a thorough health evaluation of tenants' needs.	A 140		
A 160	481-69.23(1)c(1) Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program retained 2 of 2 tenants reviewed who depite interventions continued to displayed physical aggression (Tenant #3 and Tenant #4). Findings include but are not limited to: 1) Record review on 3/17/25 revealed documenation indicating Tenant #3 was a danger towards others. Progress notes indicated the following: - A 90-day nurse review dated 1/2/25 noted Tenant #3 displayed behaviors and agitation at times and took trazodone three times daily for this. - On 1/3/25 Tenant #3 hit staff multiple times while being toileted. - A call was made to Tenant #3's primary care provider (PCP) on 1/4/25 about her behaviors. - On 1/5/25 Tenant #3 was very aggressive during morning cares. She yelled, screamed, hit,	A 160		

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A 160	Continued From page 13	A 160		

kicked and threw items at staff.
- On 1/13/25 refused incontinence cares and tried to push the door closed on staff while screaming. She became aggressive at another staff member and hit them with her walker, as well as punched them and dug her nails into their wrist and cursed at them.
- On 1/19/25 threw her spoon at another tenant. When staff tried to redirect her, she threw a medication cup at the same tenant. When staff tried to get her to leave the area she punched and kicked staff and threw her walker at her.
- On 1/22/25 she was scratching, swinging at, and biting staff when getting her to change her soiled brief and get into the shower.
- On 1/26/25 the tenant threw her meds this morning. She then grabbed staff's arms and dug her nails into staff's wrists. She was also punching staff.
- On 1/27/25 Tenant #3 kept digging nails into staff this morning when dressing. She was very aggressive and was yelling and trying to throw her walker at staff the entire time.
- On 1/27/25 the PCP increased Tenant #3's dose of trazodone.
- On 1/29/25 the tenant was combative with staff during shower. She kicked, hit, and tried to bite staff. She was cursing staff out and tried to spit on staff during the shower.
- On 1/31/25 Tenant #3 stabbed staff with a fork.
- On 2/5/25 agitated all morning, yelling at others and hitting staff. She refused to go to the bathroom and was incontinent of BM on a chair in the sunroom. While trying to take her to the bathroom, she attempted to smear BM on staff.
- On 2/26/25, Tenant #3 was combative with staff during her shower. She punched, scratched, cursed and screamed. She whipped her clothes and soiled clothing at staff.
- On 3/13/25, Tenant #3 was incredibly

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	S0492	A. BUILDING: _____ B. WING _____	C 03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVIGATE MC AT FEATHERSTONE AT HICKOF	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 160	Continued From page 14	A 160		

aggressive as staff got her ready for the day. She punched at staff's arms and hands and hit her multiple times in the stomach. This has become an every day battle with this tenant.

A review of Tenant #3's service plan revealed a section on behavior. There was an entry, updated on 10/8/24, which noted she had a history of disruptive, aggressive or socially inappropriate behavior.

On 3/17/25 at 10:45 AM, Staff F reported Tenant #3 was very aggressive. No matter how staff approached her she would hit, punch, bite, scratch, kick or throw her soiled clothing at you. This was an issue every day.

On 3/17/25 at 11:32 AM, Staff G stated Tenant #3 would scratch and bite staff when they assisted her with personal cares. This occurred each day. She regularly yelled at staff and called them names.

2) Record review of progress notes on 3/17/25 for Tenant #4 revealed the following acts of aggression:
- On 11/20/24, Tenant #4 was noted to be aggressive with staff for the past couple of weeks. He would clench his fists, swing and yell at staff when they talked to him.
- A 90-day review completed on 1/13/25 noted Tenant #4 had displayed some agitation, leading to an increase in the medication Abilify.
- When staff tried to take off Tenant #4's shoes on 1/19/24, he tried to kick and hit them.
- On 1/27/25, Tenant #4 tried to punch two staff members as they helped get him ready for bed.
- Tenant #4's Abilify was increased on 1/28/25.
- Tenant #4 kicked staff when they tried to get him up for the day on 1/29/25.

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A 160	Continued From page 15 - On 2/5/25, Tenant #4 swung his fists and yelled at staff as they tried to get him dressed. - Two staff needed to assist Tenant #4 with toileting on 2/7/25 due to his level of agitation. He kept grabbing staff's wrists and trying to push them. - A change of condition was completed on 2/10/25. In the progress note, the nurse documented Tenant #4 was often combative and resistive to cares. - Tenant #4 was resistive to cares on 2/12/25 and punched aides. - On 3/15/25, Tenant #4 refused to go to the restroom all morning. When staff directed him toward the bathroom, he pushed them. Tenant #4 had a service plan dated 2/10/25. The service plan noted he exhibited inappropriate behaviors such as urinating and defecating in inappropriate places. He was often combative with staff during cares. 3) On 3/18/25 at 3:51 PM the Executive Director confirmed Tenant #3 and Tenant #4 displayed aggression and it was inappropriate to retain them at the program.	A 160		
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually.	A 360		

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A 360	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to update the service plans of 4 of 9 tenants reviewed when they experienced a significant change in condition (Tenants #1, #2, #3, #7). Findings include, but are not limited to: 1) Record review on 3/17/25 revealed Tenant #2 was diagnosed with Dementia and Type II Diabetes Mellitus. He moved to the program on 1/13/25. Tenant #2's service plan was updated on 2/10/25 to note he wandered aimlessly or in an undirected fashion without definable or obtainable purpose, such as looking for visitors who were not coming or relatives who may be deceased. He was not a disturbance to others. A review of progress notes indicated the following: - On 2/10/25, Tenant #2 was noted to enter other tenants' rooms and lay on their beds. He refused to get out of the beds and it would take 2 staff to get him out of the apartments. - On 2/24/25, he was found in another tenant's bed. He refused to get out and staff had to physically pull him out of the bed. - Tenant #2 was found in another tenant's room on 2/26/25. He tore up the bedding and put the blankets and pillows in the sink and shower. He ripped the bedding off the bed. He refused to get out of the bed and it took two aides to pull him out of the bed. - On 2/28/25, Tenant #2 was found in another tenant's room with a chair tipped over, squatting over the side of the chair and defecating onto the back of the chair. - On 3/5/25, he was found in another tenant's bed and refused to get up. Staff had to approach him multiple times to get him to leave the	A 360		

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apartment.
- Tenant #2 entered another tenant's room and layed in his bed on 3/9/25. The other tenant became agitated, grabbed his arm and scratched him. Tenant #2 sustained two cuts on the back of his left hand and one cut on his left forearm.
- Tenant #2 was found in another tenant's room at 11:58 AM on 3/12/25. He would not exit the room and four staff members tried to remove him. It took five staff to get him out of the apartment. Later that evening at 7:40 PM, Tenant #2 entered Tenant #1's room and covered her face with a blanket. He was removed from the apartment by staff.
- On 3/13/25, Tenant #2 was found in another tenant's apartment naked with poop smeared on the bed, floor, bathroom door and himself.

On 3/17/25 at 10:45 AM, Staff F reported it was not unusual for Tenant #2 to be in everyone's room but his own. When he went to other tenant's apartments, it could take 2-3 staff to get him out of the room. Staff F was never directed by the program nurse to complete frequent supervision checks of Tenant #2.

On 3/18/25 at 10:45 AM Staff E recalled the incident from 2/28/25 in which she found Tenant #2 in another tenant's room. There was a chair knocked over and Tenant #2 was sitting on the chair with his pants down and he had pooped and urinated on the chair. It took two staff to provide incontinence cares and encourage him to leave the room. Staff E reported they were supposed to check on tenants every two hours. She was never told to check on Tenant #2 more frequently even though he entered other's apartments.

On 3/17/25 at 11:32 AM Staff G stated he usually locked other tenants' doors because Tenant #2

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A 360	Continued From page 18	A 360		

liked to sleep in their beds. No one ever directed him to check on Tenant #2, or any other tenant, more frequently.

The program did not update Tenant #2's service plan to address his wandering into other tenants' apartments. They did not add safety checks to his plan to ensure staff were closely monitoring him to prevent him from entering other tenants' apartments.

2) Record review on 3/17/25 revealed a progress note dated 3/11/25 (late entry) of a care conference between the Executive Director, Interim Registered Nurse (RN), Sales Counselor, and Tenant #1's daughters. During the meeting, Tenant #1's daughters expressed concerns about the administration of evening medication. They said staff members were not propping her head up so the medication was drooled onto her pillow, resulting in her not receiving the full dose. The Interim RN put an order into the electronic documentation system under the orders tab notifying staff to elevate the head of Tenant #1's bed for medication administration and follow with water.

On 3/20/25 at 9:20 AM Staff G reported he was not aware of there being an orders tab on the electronic documentation system. He was not notified by the Interim RN of the need to elevate the head of Tenant #1's bed when administering medication or to follow her pills with a drink of water.

On 3/20/25 at 9:20 AM Staff F stated she was not aware of an orders tab on the electronic documentation system. She was not directed by the Interim RN to raise the head of Tenant #1's bed when administering her medication.

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A 360	Continued From page 19 Tenant #1 had a service plan dated 12/16/24. The service plan identified staff were to administer her medication due to her loss of cognition. There were no directions to staff on the service plan about staff raising the head of Tenant #1's bed and following her pills with a drink of water to ensure she ingested all of her medication. 3) Record review on 3/19/25 revealed Tenant #7 moved to the program on 1/27/25. He was diagnosed with Parkinson's Disease, unspecified abnormalities of gait and mobility, neurocognitive disorder with lewy bodies and dementia. A review of incident reports and progress notes revealed he experienced falls on the following dates: - Tenant #7 was found laying face down on the floor of his room on 1/28/25 at 8:40 PM. He damaged a table during the fall and had bleeding on the back of his head. His family took him to the emergency room where he was treated for a 5 cm. laceration to the back of his head. - On 2/2/25 at 11:51 PM, during safety checks, staff found Tenant #7 with blood all over his head. His wife came and took him to the emergency room. He had a 2.5 inch laceration to the back of his scalp which was treated with staples. - Tenant #7 was found on the floor next to his recliner on 2/26/25. He reported sliding out of his recliner. - Staff heard Tenant #7 calling out for help from the sun room on 3/1/25. He reported he skidded and fell on his left side. He had a scrape on the front left side of his head. - Tenant #7 was found with a small cut to the back of head on 3/7/25. - On 3/15/25, Tenant #7's wife came to take him to the emergency room to see if he needed to get a head and neck CT due to his unwitnessed injury. The CT was performed with no injury	A 360		

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found. He got two staples to his wound.
- On 3/18/25, Tenant #7 was found outside of another tenant's room in the hallway on the ground. No injuries were noted.
- Tenant #7 was found on the floor in the dining room by staff after they heard a crash on 3/19/25.

Tenant #7's service plan dated 2/28/25 noted he was able to ambulate independently without a mobility device. He had a walker should he need to use it. Staff were to ensure his room was clutter free and easy to navigate. There were no recommendations as to how often staff should provide supervision checks of Tenant #7.

On 3/18/25 at 3:20 PM, Staff F reported she provided extra supervision checks for Tenant #7 due to his tendency to fall, although the program RN had not directed her to do so.

On 3/18/25 at 2:55 PM, Staff G stated Tenant #7 had experienced 3-4 falls and received stitches, so he liked to check on the tenant more often, he though he had not been directed to do so.

On 3/25/25 at 11:15 AM the Interim RN stated Tenant #7 should use his walker when ambulating, but forgot at times due to his cognitive impairment.

The Executive Director confirmed his service plan did not include any directions about his level of supervision due to his history of falls.

4) Record review on 3/17/24 revealed progress notes documenting aggressive acts involving Tenant #3, to include:
- A 90-day nurse review noted Tenant #3 displayed behaviors and agitation at times and took trazodone three times daily for this.

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A 360	Continued From page 21 - On 1/3/25, Tenant #3 hit staff multiple times while being toileted. - A call was made to Tenant #3's primary care provider (PCP) on 1/4/25 about her behaviors. - On 1/5/25, Tenant #3 was very aggressive during morning cares. She yelled, screamed, hit, kicked and threw items at staff. - refused incontinence cares on 1/13/25 and tried to push the door closed on staff while screaming. She became aggressive at another staff member and hit them with her walker, as well as punched them and dug her nails into their wrist and cursed at them. - threw her spoon at another tenant on 1/19/25. When staff tried to redirect her, she threw a medication cup at the same tenant. When staff tried to get her to leave the area she punched and kicked staff and threw her walker at her. - On 1/27/25, the PCP increased Tenant #3's dose of trazodone. - agitated all morning, yelling at others and hitting staff. She refused to go to the bathroom and was incontinent of BM on a chair in the sunroom. While trying to take her to the bathroom, she attempted to smear BM on staff. - On 2/26/25, Tenant #3 was combative with staff during her shower. She punched, scratched, cursed and screamed. She whipped her clothes and soiled clothing at staff. - On 3/13/25, Tenant #3 was incredibly aggressive as staff got her ready for the day. She punched at staff's arms and hands and hit her multiple times in the stomach. This has become an every day battle with this tenant. A review of Tenant #3's service plan revealed a section on behavior. There was an entry which was updated on 10/8/24 noting she had a history of disruptive, aggressive or socially inappropriate behavior.	A 360		

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A 360	Continued From page 22 On 3/17/25 at 10:45 AM, Staff F reported Tenant #3 was very aggressive. No matter how staff approached her, she would hit, punch, bite, scratch, kick or throw her soiled clothing at you. This was an issue every day. On 3/17/25 at 11:32 AM, Staff G stated Tenant #3 would scratch and bite staff when they assisted her with personal cares. This occured each day. She regularly yelled at staff and called them names. Tenant #3's service plan was not updated to add interventions to address her physical aggression. 5) On 3/25/25 at 11:15 AM the Executive Director confirmed tenants' service plans were not updated to address their needs.	A 360		
A 415	481-69.26(4)e Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: e. Preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to identify a preference for nursing facility care on the service plan for 3 of 4 tenants reviewed (Tenant #1, Tenant #2 and Tenant #4). Findings follow:	A 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 415	Continued From page 23 Record review on 3/25/24 of 3 service plans revealed they all included the language "choice of long term care facility of choice should a higher level of care be needed is undecided at this time" including: Tenant #1's 12/16/24 service plan Tenant #2's 2/15/25 service plan Tenant #4's 2/10/25 service plan On 3/25/25 at 11:15 AM the Interim Registered Nurse reported she does not ask tenants or their legal representatives about their choice of nursing facility care. This information auto populates on the service plan.	A 415		

FEATHERSTONE
AT HICKORY HILL

April 28, 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 Navigate Memory Care at 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 3/17/2025 to 3/25/2025. 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.

Program Policies and Procedures A 130

1. **Correction of Regulatory Insufficiencies**
- The incident policy has been updated to reflect the language in 67.2(1).
2. **Measures to Prevent Recurrence**
- Associates will be provided with an in-service on the new policy.
3. **Monitoring for Compliance**
- Compliance will be reviewed at quarterly QAPI meetings for four quarters. The team will review for compliance, update and make recommendations as needed.
4. **Completion Date: 5/20/2025**

Program Policies and Procedures A 150

1. Correction of Regulatory Insufficiencies
- Clinical staff will be re-educated on Incident Reports to be filled out for all accidents or unusual occurrences that affect tenants.

2. Measures to Prevent Recurrence
- The Executive Director and/or designee will conduct Audits audits weekly times three weeks, then quarterly for four quarters will be completed regularly to ensure that Incident Reports are being completed, and we are in compliance.

3. Monitoring for Compliance
- Compliance will be reviewed at quarterly QAPI meetings for four quarters. The team will review for compliance, update and make recommendations as needed.

4. Completion Date: 5/20/2025

Tenant Rights A 160

1. Correction of Regulatory Insufficiencies

- The Resident Services Director or delegated designee will inservice and delegate the need for routine safety checks every 2 hours, or per the resident's service plan.
- The Resident Services Director or delegated designee will inservice clinical associates on reporting abnormal vitals signs or changes of condition to the RN.

2. Measures to Prevent Recurrence

- Safety checks will be put on the task list for clinical associates.
- The Resident Services Director or delegated designee will review the resident vitals on the 24- or 72-hour report and retake vital if out of normal range.

3. Monitoring for Compliance

- The incidents will be reviewed at the morning PCC review meeting daily.
- Resident Services Director or delegated designee will notify PCP and POA of abnormal vital signs unless otherwise noted in chart.

4. Completion Date: 5/2/2025

Medications A 285

1. **Correction of Regulatory Insufficiencies**
    - Staff E has been re-inserviced, competencied and re-delegated on following physician orders during medication administration.
    - QMAs will be re-inserviced, competencied and re-delegated on following physician orders during medication administration.
2. **Measures to Prevent Recurrence**

- The Resident Services Director or delegated designee will audit medications weekly times four weeks to ensure correct doses of medication are available.
- The Resident Services Director or delegated designee will randomly audit two medication passes weekly times four weeks to ensure medications are administered per physician orders.

3. **Monitoring for Compliance**
    - The Resident Services Director or delegated designee will inservice QMAs to contact on call RN if medication is missing or incorrect dosage. RN to follow up with PCP and POA.
4. **Completion Date: 5/2/2025**

Evaluation of Tenant A 135

1. Correction of Regulatory Insufficiencies

- The preadmission and admission assessment will be updated to contain evaluation of the resident's health status.

2. Measures to Prevent Recurrence

- Residents will be reassessed utilizing the revised assessment including their health status.

3. Monitoring for Compliance

- Compliance will be reviewed during quarterly QAPI meetings. The team will review assessments and ensure the health portion of the assessment are being completed.

Completion Date: 5/20/2025

Evaluation of Tenant A 140

1. Correction of Regulatory Insufficiencies

- Resident # 3 was provided with a 30 day discharge notice.
- Resident # 4 is on hospice and behaviors have decreased with updated orders

2. Measures to Prevent Recurrence

- The community will monitor residents daily for inappropriate behaviors including monitoring the 24-hour report.
- Interventions will be put in place and resident service plans will be updated accordingly. If resident behavior continues, resident will be given a 30-day discharge notice.

3. Monitoring for Compliance

- The community will review medical records od residents with behaviors for patterns and if interventions are not working we will issue a 30-day notice to residents, POA and Ombudsman.

Completion Date: 5/20/2025

Criteria for Admission/Retention of Tenants A160

1. Correction of Regulatory Insufficiencies

- Resident # 3 was provided with a 30 day discharge notice.
- Resident # 4 is on hospice and behaviors have decreased with updated orders

2. Measures to Prevent Recurrence

- The community will monitor residents daily for inappropriate behaviors including monitoring the 24-hour report.
- Interventions will be put in place and resident service plans will be updated accordingly. If resident behavior continues, resident will be given a 30-day discharge notice.

3. Monitoring for Compliance

- The community will review medical records od residents with behaviors for patterns and if interventions are not working we will issue a 30-day notice to residents, POA and Ombudsman.

Completion Date: 5/20/2025

Service Plans A 360

1. Correction of Regulatory Insufficiencies

- Residents #1, # 2, 3 no longer reside in the community. Resident #7 has had their service plans reviewed and updated as needed.

2. Measures to Prevent Recurrence

- Resident Service Director or delegated designee will audit current residents service plans and update service plans as needed.

3. Monitoring for Compliance

- Resident Service Director or delegated designee will audit current residents service plans and update service plans as needed.

4. Completion Date: 5/2/2025

Service Plans A 415

1. Correction of Regulatory Insufficiencies

- The assessment tools for residents #4 has been updated to include nursing home preferences per 69.26(4) Residents #1 and #2 no longer reside in the community. The community will audit to ensure all tenants have this information in their service plan.

2. Measures to Prevent Recurrence

- •The nursing team will be required to review and document nursing home preferences during pre-occupancy assessments. Education will be provided to ensure that the clinical team is aware of how to meet this requirement.
- The Executive director will conduct monthly audits on all new tenants for the next 3 months to ensure this requirement is being met.

3. Monitoring for Compliance

- The Executive Director will conduct monthly audits on all new tenants for the next 3 months to ensure this requirement is being met.

4. Completion Date: 5/2/2025

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

Sincerely,

Tracy Sherzer, Executive Director

✓ 5.15.25