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 _____	R-C 06/11/2025

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 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: 15 Total census: 15 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}		
{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	{A 135}		

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{A 135}	Continued From page 1 evaluation prior to occupancy for 1 of 1 tenants reviewed who was admitted within the previous month (Tenant #4). Findings follow: Record review on 6/10/25 revealed Tenant #4 was admitted to the program on 5/20/25. The program nurse initiated the Iowa Assisted Living Assessment on 5/20/25 which evaluated Tenant #4'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 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.	A 145		

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A 145	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the program failed to evaluate the health, cognitive and functional needs of 3 of 7 tenants reviewed when they experienced a significant change in condition (Tenant #2, Tenant #6 and Tenant #7). Findings follow: 1) Record review on 6/9/25 revealed Tenant #2 had an Iowa Assisted Living Assessment dated 5/16/25 and service plan dated 5/19/25 which noted she had behaviors such as wandering aimlessly or in an undirected fashion. A review of progress notes identified on 5/28/25 while an aide was administering her medication, Tenant #2 told a tenant who was passing by to shut up and leave. On 5/29/25 she was noted to have visual and auditory hallucinations. A progress note from Tenant #2's PCP dated 5/29/25 revealed she was seen for a follow up due to an increase in agitation, hallucinations and verbally abusive behaviors. When the PCP approached Tenant #2 she yelled, "I am very angry right now." Staff reported to the PCP the tenant was experiencing some hallucinations and paranoia. The PCP directed staff to continue to monitor Tenant #2's moods and behaviors closely. She educated the staff at the program on the importance of consistent routines and gentle redirection techniques to minimize agitation. During an observation on 6/11/25 at 8:20 AM, Tenant #2 yelled at another tenant who spilled a glass of water at breakfast. The program nurse updated Tenant #2's service	A 145		

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A 145	Continued From page 3	A 145		

plan on 5/29/25 after she experienced a change in her condition and noted she exhibited inappropriate behavior such as showing anger due to visual and auditory hallucinations, but failed to evaluate her cognitive, health and functional condition.

2) Tenant #6 had an Iowa Assisted Living Assessment and service plan dated 4/4/25. The documents identified staff were to encourage him to eat soft food and sweets. They were to keep the head of his bed elevated for 30 minutes after he finished eating. He required the assistance of 3 staff members using a gait belt to help him with transferring. Tenant #6 was on hospice and the nurse indicated he was on comfort cares, indicating he was near the end of his life.

A review of progress notes for Tenant #6 revealed the program nurse reached out to the hospice nurse on 5/9/25 to discuss his care. The hospice nurse reported his condition had improved and he was no longer in his final days of life. A care conference was held on 5/20/25 to discuss his needs. He needed more assistance with transfers and feeding as he was increasingly active. Tenant #6 was found face down on the floor during safety checks on 6/12/25 at 3:03 AM. He had a skin tear on his left elbow. Facial grimacing was noted when he moved his left elbow. The PCP was going to fax wound care orders to the program.

During a meeting with Tenant #6 on 6/11/25 at 11:45 PM, he had an oxygen concentrator in his room. Oxygen tubing with a nasal cannula was laying on the floor where it had been removed/fallen off him. Staff C put the oxygen back on Tenant #6.

The program nurse made several changes to

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A 145	Continued From page 4	A 145		

Tenant #6 service plan on 5/20/25. She noted Tenant #6 would eat meals in his room as he was bed bound. He was no longer in his final days. He would remain in bed with every 2 hour position changes until a decision was made on how to safely transfer Tenant #6. He had a history of harming others and would strike out at staff during transfers due to anxiety. Tenant #6's use of oxygen was not mentioned on the service plan. The nurse did not re-evaluate Tenant #6's health, cognitive or functional needs when he had a change of condition leading her to update his service plan on 5/20/25.

3) The program nurse completed an Iowa Assisted Living Assessment for Tenant #7 on 2/10/25. She identified he was independent with transferring. He did not require staff assistance with mobility. His service plan from 2/10/25 made no reference of mobility issues or transfer needs. It did not identify Tenant #7 was at risk for falls.

A review of progress notes and incident reports revealed the following:
- On 4/8/25, the nurse was called to the dining room. Staff reported Tenant #7 was walking with a gait imbalance and leaning to the right. Staff were encouraged to assist him with ambulation until the issue resolved.
- Tenant #7 was found on the floor in one of the sunrooms on 4/16/25. He was unable to tell staff what happened.
- Staff reported to the nurse on 5/3/25 and 5/5/25 Tenant #7 was unsteady on his feet with jerky body movements. The nurse notified the family and hospice of this.
- A care conference was held with Tenant #7's wife, hospice nurse and program representatives on 5/9/25. They discussed his care needs and issues with transfers. The service plan was

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A 145	Continued From page 5	A 145		

updated.
- Tenant #7 was found lying on his side against the windowsill in the sunroom on 5/20/25 at 11:32 AM. He was about 20 feet away from his wheelchair.
- On 5/22/25 at 7:30 AM Tenant #7 was found laying on his left side by his bed. He had a small scrape to his right elbow.
- The program nurse was notified of skin changes to Tenant #7's right heel on 5/23/25. They received orders for dressing changes every three days with heel protector boots on 5/24/25.
- The hospice nurse reported Tenant #7 had stage one pressure wounds to his bilateral heels on 5/27/25. The hospice nurse and program nurse would change the dressings to his wounds.
- Staff notified the nurse on 6/3/25 at 9:38 PM of edema in Tenant #7's right lower extremity. He also had redness in his right foot, which was warm to the touch. Staff were instructed to keep his feet elevated. The nurse assessed him on 6/4/25 and discovered he had 3 plus pitting edema to his bilateral feet. Both lower extremities were red but of an appropriate temperature.
- Tenant #7 required the assistance of 2 staff to transfer from bed to his wheelchair on 5/28/25 and 6/5/25.

The program nurse made updates to Tenant #7's service plan on 4/16/25 to note he was at risk for falls, on 5/24/25 to note he had a pressure ulcer on his right heel, on 6/4/25 to identify he had edema in his bilateral feet and on 6/9/25 to note he needed the help of 1-2 people to get out of bed. The program nurse did not evaluate Tenant #7's health, functional or cognitive condition before updating his service plan when he experienced these changes to his condition.

4) The Residential Services Director and Memory

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A 145	Continued From page 6 Care Manager confirmed the program failed to complete evaluations for the tenants reviewed when they experienced changes in their conditions.	A 145		
A 530	481-69.29(4) Staffing 481-69.29(231C) Staffing. 69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans. A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure staff checked on 1 of 7 tenants reviewed as indicated in her service plan (Tenant #5). Findings follow: Record review on 6/10/25 revealed a progress note from the Family Nurse Practitioner (FNP) identifying Tenant #5 was seen on 3/27/25 following an unwitnessed fall on 3/21/25. Staff were not sure what happened, but she seemed to	A 530		

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A 530	Continued From page 7	A 530		

be attempting to walk and/or stand from her wheelchair. She had a fall a few days previously as well as an injured elbow. Staff at the facility were to continue to monitor Tenant #5 per facility protocol and provide safety/fall precautions. They were to assist and redirect Tenant #5 as needed.

A review of program progress notes revealed the following:
- on 5/2/25 Tenant #5 was noted to be restless and attempting to walk frequently. She was normally unsteady on her feet.
- on 5/8/25 she had a fall. Deformity, swelling and bruising was noted to her nose.
- on 5/9/25 the tenant had another fall.
- on 5/10/25 she was found to have a swollen nose and dark purple bruising to both eyes.
- on 5/13/25 she was restless and wandering frequently.

A care conference was held on 5/16/25 with the Residential Service Director (RSD), Memory Care Manager and the tenant's daughter. They discussed Tenant #5's restlessness and wandering into others' apartments. They came up with a plan to keep Tenant #5 safe which included increasing her level of supervision. Tenant #5's service plan was updated on 5/16/25 with an intervention for staff to observe her in the community/common areas per protocol, which was every hour.

Additional progress notes documented the folowing:
- on 5/19/25 the tenant was noted to be wandering the halls frequently while unsteady on her feet. Tenant #5 required a staff member to frequently walk with her.
- on 6/4/25 was found on the ground in front of her wheelchair in the living room.

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A 530	Continued From page 8 A review of a Response History form revealed the program started conducting supervision checks for Tenant #5 every two hours beginning on 5/29/25 and continuing through 6/10/25 (conclusion of investigation). There was no evidence the program had completed checks prior to 5/29/25. On dates when the checks were conducted, many two hour blocks of time were documented within a few minutes. For example, on 5/30/25 checks from 12:00 AM to 8:00 AM were all checked off by staff between 5:20 AM and 5:21 AM. On 6/4/25, staff documented the seven hours of checks from 8:00 AM to 2:00 PM at 1:08 PM. On 6/7/25, staff documented they conducted the 6 hours of checks from 2:00 PM to 7:00 PM at 7:22 - 7:23 PM. The RSD reported on 6/11/25 at 2:22 PM she instructed staff to document their checks on Tenant #5 at the time they were completed, not at the end of their shift. She confirmed the program failed to ensure Tenant #5 was supervised according to her service plan beginning on 5/16/25. The program did not provide a method for staff to document the supervision checks until 5/29/25.	A 530		