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 02/09/2026

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. Tenants without cognitive impairment: 2 Tenants with cognitive impairment: 23 Total census: 25 There were no regulatory insufficiencies cited during the investigation of Incident #130721-I and Incident #131205-I. The following regulatory insufficiency was cited during the investigation into Incident #131198-M and Complaint #131195-A.	A 000	See attached POC 1/16/26	
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: Based on interview and record review, the Program failed to administer medication as ordered by the tenants ' physician to 2 of 3 current tenants reviewed (Tenant #1 and Tenant #2). Findings follow:	A 285		

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

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A 285	Continued From page 1 1. Record review on 1/14/26 revealed Tenant #1 was diagnosed with undifferentiated connective tissue disease, osteopenia, osteoarthritis and vascular dementia. An After Visit Summary (AVS) dated 12/23/25 revealed she went to the Rheumatology clinic on 12/23/25 and was prescribed Methotrexate Sodium. The Licensed Practical Nurse (LPN) at the Program initialed she received the AVS on 12/26/25 at 1500. The AVS noted Tenant #1 was to receive Methotrexate Sodium 15 mg. (6 tabs; 3 in the morning and 3 in the evening) once a week. The LPN entered the order into the Program's Electronic Medication Administration Record (EMAR) on 12/26/25 to read: Methotrexate Sodium oral tablet 15 mg. "give 3 tablets by mouth two times a day for other." The bottle held 2.5 mg. tablets, so each dose was 7.5 mg, or 15 mg. per day. A review of progress notes showed the order the LPN input generated a warning: this order is outside the recommended dose or frequency. The dosing regimen exceeded the usual dosing regimen of 0.25 to 1.667 tablets every 7 days. The LPN overrode the warning on 12/26/25. The Program contracted with a pharmacy which managed the EMAR system. The pharmacy faxed the Program on 12/26/25 questioning the dose of the Methotrexate Sodium as it was generally administered weekly, not daily. No one from the Program responded. Tenant #1's friend brought the bottle of Methotrexate Sodium to the Program from a community pharmacy on 12/29/25 and she had her first dose of the medication that evening, as	A 285		

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A 285	Continued From page 2	A 285		

seen on the December, 2025 EMAR. The Program began administering Tenant #1 the Methotrexate Sodium daily rather than once a week. She received the medication twice daily through 1/08/26.

A pharmacist sent a second fax to the Program on 12/29/25 asking them to clarify the directions on the Methotrexate Sodium order. The LPN responded with a message on 12/29/25 via fax: She gets meds from a different pharmacy. The LPN did not address the question about the dosing schedule.
A further review of progress notes revealed on 1/05/26 the nurse was called to Tenant #1's room by her friend. Tenant #1 was noted to have itchy bumps on her chest, bilateral arms and back. There were no open areas or drainage noted. Tenant #1 was referred to the urgent care clinic where she was diagnosed with a bacterial skin infection. On 1/09/26 her rash was spreading.. She went to the emergency room. Tenant #1 was admitted to the hospital.

Hospital records dated 1/09/26 to 1/22/26 revealed Tenant #1 presented to the emergency room with painful mouth lesions and bleeding from the nose. She had new pancytopenia with neutropenia (a critical condition defined by a simultaneous, dangerous drop in all three blood cell lines - red cells, platelets, and white cells, specifically neutrophiles), concerning for Methotrexate toxicity and/or severe drug reaction. She was admitted for management of suspected Methotrexate toxicity and monitoring for complications.

Tenant #1's stay was complicated by a neutropenic fever. It was further complicated by

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pancytopenia requiring transfusions. She required four units of red blood cells and two units of platelets. Her counts subsequently stabilized and no transfusions were necessary on 1/19/26. Tenant #1 had electrolyte abnormalities during her hospitalization which resolved with the initiation of oral supplementation and intermittent IV (intravenous) replacement of electrolytes. Speech pathology evaluated Tenant #1 on 1/21/26. Speech pathology recommended she discharged on an easy to chew diet with thin liquids. Tenant #1's oral intake improved as the lesions in her mouth healed. The hospital discharged Tenant #1 back to the Program on 1/22/26.

When interviewed on 1/14/26 at 1:20 p.m. the Memory Care Manager reported when Tenant #1 went to the emergency room, the hospital nurse called the Program to reconcile the medication list. This was when the Program realized Tenant #1 received the incorrect dose of Methotrexate Sodium.

During an interview on 1/14/26 at 3:25 p.m. Staff A recalled talking with the LPN on the first date she was to administer Methotrexate Sodium to Tenant #1 (12/30/25). She informed the LPN the label on the bottle of Methotrexate Sodium did not match the directions on the EMAR. The LPN told Staff A the EMAR was correct and she needed to follow those directions. Staff A recalled Tenant #1 got a rash on her ear which then spread to her entire body.

When interviewed on 1/15/26 at 2:45 p.m. Staff B worked with Staff A who asked her to look at the bottle of Methotrexate Sodium and compare it to the EMAR. She reviewed the two and agreed

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they did not match. They contacted the LPN and asked her to review the situation. Staff B described the LPN's reaction to their query as dismissive. The LPN looked at the bottle and the EMAR. She then told them to follow the EMAR. The Resident Services Director was interviewed on 1/15/26 at 8:30 a.m. and 2/06/25 at 10:00 a.m. . She reported the LPN incorrectly entered the order for Tenant #1's Methotrexate from the 12/23/25 AVS. The LPN overrode the warnings she received from the EMAR system. The LPN was trained to put the medication order on hold and notify the physician about the dosing instructions when the warning came up. When Tenant #1's friend brought her medication to the Program on 12/29/26, a nurse failed to check the label before putting it in the medication cart for staff to administer. The LPN ignored the faxes from the pharmacy questioning the scheduling of the Methotrexate Sodium. Staff administered the Methotrexate Sodium knowing the label did not match the MAR. The Program failed to properly administer medication to Tenant #1.

2) Review of a medication error form for Tenant #2 on 1/15/25 revealed she received Aspercreme three times daily when it should have been administered PRN, or as needed. The nurse contacted the Resident Services Director and assessed Tenant #2's skin and there were no signs of irritation.

On 1/15/26 at 12:56 p.m. the Resident Services Director confirmed the program did not administer Tenant #2's Aspercreme as prescribed.

FEATHERSTONE
AT HICKORY HILL

March 10, 2026

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

Dear Ms. Campbell:

On behalf of Navigate at FeatherStone at Hickory Hill, I respectfully submit our Plan of Correction for your approval. My response is specific to the self-report investigation visit that was conducted between 1/14/2026 to 2/9/2026. 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.

Medication Management A285

1.Correction of regulatory insufficiencies

Incorrect medication orders corrected in the EMAR to match physicians' order. Nursing staff re-educated on proper medication order transcription, verification procedures and ensuring all medication labels and Emar match before administration.

2.Measures to prevent recurrence

All pharmacy alerts on PCC dashboard will be reviewed daily. RSD or designee will audit 5 residents' medication orders and alerts weekly for 90 days then quarterly.

3.Monitoring for compliance

Medication order accuracy audits will be reviewed at QA meetings to identify trends and ensure sustained compliance. QA meetings will be held monthly for 90 days, then quarterly.

Completion date: January 16, 2026

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

Sincerely,

Tracy Sherzer, Executive Director