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
	S0243	A. BUILDING: _____ B. WING _____	C 05/21/2026

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ADDINGTON PLACE OF CLINTON	1701 13TH AVENUE NORTH CLINTON, IA 52732

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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. Tenants without cognitive impairment: 50 Tenants with cognitive impairment: 17 Total census: 67 There were no regulatory insufficiencies cited during the investigation of Incident #130808-I. The following regulatory insufficiencies were cited during the investigation of Complaint #130919-C, Complaint #131752-C, Complaint # 131951-A, Complaint # 131959-A, Incident #131976-M and the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia.	A 000	See attached POC 9/7/26	
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 follow established policy regarding abuse, neglect, and mistreatment and incident reporting (including allegations of dependent adult abuse). The Program failed to ensure allegations were reported to leadership immediately, thoroughly investigate allegations of abuse, ensure protections for tenants from further abuse, and report suspected dependent adult abuse to the appropriate state agency. Furthermore, the Program failed to ensure completion of incident reports, notify appropriate parties, and ensure	A 116	**Tag 116 481-67.2(2)** **Program Policies and Procedures** **Corrective Action**: ED/DHW will review current incidents and allegations to ensure required reporting, investigation, protections, notifications, and documentation are complete. **Prevention:** Staff will be re-educated on abuse, neglect, exploitation, incident reporting, and immediate leadership/state notification requirements. **Monitoring**: ED/designee will audit 100% of incidents weekly for 6 weeks, then monthly until 12/31/2026. **Correction Date**: 9/7/2026	

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

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documentation in the tenant record. This pertained to 7 of 19 current tenants reviewed (Tenant #2, Tenant #10, Tenant #15, Tenant #16, Tenant #17, Tenant #18, Tenant #19). Findings follow:

1) a. Record review of a counseling documentation form for Staff N dated 12/18/25 indicated a thorough investigation was completed regarding her inappropriate conduct toward tenants which violated the code on Quality of Care and Standard of Conduct. The investigation confirmed the conduct did not align with program policies. Based on these findings, employment was being separated. The allegations involved verbally inappropriate behavior toward a tenant in memory care on 12/6/25. It also involved possible physical abuse toward a tenant in memory care on 12/10/25.

On a Staff Documentation/Communication to RN form dated 11/22/25 at 2:50 AM Staff F wrote she and Staff E were able to hear Staff N and Staff O telling Tenant #2 to get away from the secured memory care door. Staff E and Staff F were standing on the opposite side of the closed door. Staff N asked Staff O to get the wheelchair (Tenant #2 did not use a wheelchair as she was able to walk). Staff F then entered the memory care unit and went toward Tenant #2's room. She heard a loud bang. Tenant #2 then asked, "Why are you guys doing this?" Staff N came out of Tenant #2's apartment with the wheelchair. She saw Staff F and told her Tenant #2 had blood on her hands because Tenant #2 was picking at her arm. Staff E then went to the memory care unit to make sure everything was okay. They helped Tenant #2 get into her pajamas and cleaned up a mark on her right arm where she was bleeding. They then left the memory care unit. At 3:45 AM

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Staff N left the memory care unit to tell Staff E and Staff F Tenant #2 had a pair of scissors and was attempting to stab them. Staff O then called over the radio reporting she needed assistance. Staff F went to the memory care unit and saw Staff O walking out of Tenant #2's apartment. Tenant #2 was in front of the employee. She was holding Tenant #2's arms and pushing her out of the apartment. Staff F asked Tenant #2 if she was okay. Tenant #2 kept asking, "Why are they doing this to me?" When Staff F got her back in her apartment she noticed blood coming from her ankle. Tenant #2 allowed Staff F to provide first aide. Staff F asked what happened and Tenant #2 reported her ankle was injured when she was put in the chair with wheels. She repeated she did not understand why they were doing this to her.

During an interview with Staff J on 4/9/26 at 1:10 PM he reported seeing Staff N act in an aggressive manner when performing cares on Tenant #2. This resulted in marks on her forearm and legs. This occurred multiple times. He believed it happened in late December. Staff J told the Registered Nurse (RN) about this via the Staff Documentation/Communication to RN forms. He handed the form to the RN personally. The RN asked him about the location of the bruising and if it looked like grabbing. One time he saw Staff N grab Tenant #2 tightly on the wrist. The tenant did not like it and said, "Ow!" and tried to pull her hand away. This resulted in finger prints along the back of the wrist and it appeared a fair amount of pressure was placed on the underside of the forearm.

Staff F was interviewed on 4/15/26 at 10:10 AM and reported she wrote up her concerns about the incident on 11/22/25 and provided them to the

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Executive Director. He spoke to her about them and said he would look into it.

During multiple interviews with the Executive Director he confirmed there was no written investigation into the incident on 11/22/25. He believed the verbal incident on 12/6/25 had to do with a video of Staff N yelling at Tenant C3. The Executive Director believed the physical abuse could have stemmed from a situation in which Staff N removed a tenant from the dining room against her will. He could not locate an investigation with witness statements into any of these situations.

b. The Program reported a theft of approximately $300 in cash to the Department of Inspections, Appeals, and Licensing on 11/10/25. The Program investigation identified Tenant #5 realized the money was gone on 11/8/25. She reported this to staff on that date. The police were notified.

The Director of Celebrations was interviewed on 4/13/26 at 12:30 PM and reported she was aware a few tenants had money stolen including Tenant #10 and Tenant #19.

During an interview on 4/14/26 at 12:50 PM Tenant #15 reported she had $60 stolen from her purse. The first thing she did was report the theft to the Executive Director.

When interviewed on 4/14/26 at 1:15 PM Tenant #17 and Tenant #18, a married couple, explained they had $60 stolen from their apartment. They kept the door locked and were gone for about 3 hours. On their return, $60 was missing from Tenant #18's wallet, all $20 bills. They immediately reported this to the Executive

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Director.

On 4/14/26 at 2:30 PM Tenant #10 reported someone took all of the $20 bills out of his wallet. He could not recall when this occurred. Tenant #10 reported this to the Executive Director but nothing else happened.

Tenant #19 was interviewed on 4/15/26 at 8:05 AM. He moved to the Program in June, 2025 and a short time later had $300 taken out of his computer desk. Tenant #19 believed it was his fault as he did not lock the door to his apartment. Staff A came and talked with him about this.

On 4/28/26 at 10:00 AM Tenant #16 was interviewed with her daughter and reported $40 was stolen from her purse. She was unsure of the date. Tenant #16's daughter reported this to the Executive Director. She was sure $40 was stolen as she had this amount of money taken out of the bank to get her hair done.

c) Record review revealed the Program's policy regarding abuse, neglect and exploitation, dated 6/13/24, directed when abuse was suspected, staff and volunteers were required to immediately provide notification to persons/agencies as described in the policy. The policy further directed the following:

a. When a staff member observed, suspected, or had knowledge of an incident appearing to be abuse should immediately report to the Director of Health and Wellness and Executive Director. In all cases, the Executive Director should be informed as soon as possible.

b. Upon notice of alleged abuse, immediate steps

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should be taken to ensure the tenant was protected from future abuse.

c. A thorough investigation should be conducted by the Director of Health and Wellness or Executive Director.

d. The resident should be interviewed and witnesses should be interviewed as necessary.

e. Family should be contacted immediately, as should the tenant's physician.

f. Abuse, neglect, and exploitation should be reported to the Iowa Department of Inspections, Appeals, and Licensing.

During multiple interviews with the Executive Director, including on 4/15/26 at 11:15 AM he reported the daughter of Tenant #17 and Tenant #18 reported the theft to him. The Executive Director said he thought Tenant #10 lost a ring but did not know he was missing cash (Tenant #10 confirmed he reported the missing cash on 4/15/26 at 1:15 PM). He initially said he did not know Tenant #19 was missing cash, but later said he learned about it a month after the fact from Staff A. The Executive Director claimed no knowledge of the theft from Tenant #16. He reported he helped Tenant #15 look for her lost money and find it (a claim she denied on 4/15/26 at 12:30 PM). The Executive Director confirmed the potential acts of abuse and exploitation were not reported to the Department.

2) a. Review of Staff Documentation/Communication to RN sheets was conducted on 4/16/25 at 11:00 AM with the Executive Director and Assistant Director of

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Health and Wellness (ADHW). Staff A reported these internal forms were given to the Registered Nurse (RN) at the time of events, but the Program failed to transition these into formal incident reports or retain them in official records. The forms described the following sequence of events involving Tenant #2:
- On 11/9/25 at 11:05 PM, Tenant #2 set off door alarms and threw a washcloth at Tenant C4.
- On 11/17/25 at 10:45 PM, Tenant #2 exhibited aggressive behavior toward staff by following Staff N and getting in the employee's face.
- On 11/22/25 between 2:50 AM and 3:45 AM, Staff F and Staff E responded to a loud bang in the memory care unit. Staff N reported Tenant #2 was picking at her skin, resulting in blood on her hands. Later, Staff N and Staff O reported Tenant #2 attempted to stab them with scissors and was found in Tenant #12's apartment. Tenant #2 sustained an ankle injury while being moved by staff.
- On 11/24/25 at 12:00 AM, Tenant #2 attempted to break glass in a hallway door, rattled handles of other tenant rooms, and targeted Tenant C4.
- On 11/26/25 at 2:20 AM, Tenant #2 showed a scratch and bruise to another tenant, stating she did not know what happened but "it's not good."

b. Additional record reviews and staff interviews identified undocumented incidents for other tenants included:
- On 10/6/25 and 10/11/25, Tenant #12 exhibited combative behavior, including hitting and kicking staff during cares.
- On 11/26/25, Tenant C1 reported a fall that occurred the previous night, resulting in pain in her right arm and shoulder.
- On 1/27/26, Tenant #12 punched Staff G and choked Staff J during cares.
- On 2/17/26, Tenant C4 ingested Tenant #12's

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A 116	Continued From page 7 evening medications after they were left unattended by Staff J. No formal incident report was generated for this medication variance. c.. During an interview on 4/15/26 at 9:25 AM, the ADHW confirmed the process required staff to complete paper reports for her to enter into the electronic system, yet the above events lacked such documentation. d. Review of the Program's Incident Report policy (dated 6/13/24) revealed a requirement to complete Internal Occurrence Reports for all unusual occurrences, injuries, and incidents. On 4/16/25, the Executive Director and ADHW confirmed the Program failed to identify these events as reportable incidents, failed to complete required forms, and failed to notify appropriate parties or document the events in tenant records.	A 116		
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 provide adequate services to 2 of 8 discharged tenants reviewed (Tenant C3 and Tenant C7), Tenant and 2 of 10 current tenants reviewed (Tenant #7 and Tenant #3). Findings follow: 1) Record review on 4/13/26 revealed an Internal	A 122	**Tag 122 481-67.3(2) Tenant Rights** **Corrective Action**: DHW will review current resident care, supervision, treatment, and visitation needs and correct any identified deficiencies. Service plans and assigned tasks will be updated as needed. **Prevention**: Staff will be re-educated on providing assessed services, required safety checks, timely response to resident needs, and resident rights. **Monitoring:** DHW/designee will audit 5 resident records weekly for 6 weeks, then monthly until 12/31/2026. **Correction Date**: 9/7/26	

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A 122	Continued From page 8 Occurrence Report form for Tenant C3 dated 1/1/26 at 7:05 AM. Staff entered Tenant C3's apartment and found him face down on the floor with his head toward the bathroom. He had blood around his head and no pulse; his skin was cold and his body was stiff. Record review revealed Tenant C3's death certificate noted the cause of death as cardiopulmonary arrest. On 12/30/25, the Nurse Practitioner noted Tenant C3 was a 96-year-old male with dementia, agitation, and anxiety. A daily task sheet from 12/31/25, 10:00 PM - 1/1/26, 6:00 AM, required 8 hourly safety checks. Staff C worked in the secured memory care unit and documented hourly checks from 2200 (10:00 PM) through 4:44 AM. When interviewed on 4/23/26 at 10:06 AM Staff C stated she worked alone in the memory care unit on 12/31/25 - 1/1/26. She could not recall the last time she checked on Tenant C3 before leaving on 1/1/26. She documented her tasks at 4:44 AM, but stated this reflected the time she completed documentation, not the time of the check. Staff C reported she hesitated to enter apartments where tenants slept because of high needs, including wandering. She reported she had to break up fights and keep others from tearing up items in their rooms such as the air conditioning unit. Almost all of the tenants were at risk of falling. She begged the Executive Director to staff two employees in the memory care unit at night. When two staff were present, they were able to provide safety checks to tenants as required. During an interview with Staff J on 4/27/26 at 2:00 PM he reported he arrived for his shift at 6:00 AM	A 122		

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on 1/1/26, and entered Tenant C3's apartment between 6:30 AM and 7:00 AM. He confirmed staff must fully visualize tenants during safety checks.

When interviewed on 4/15/26 at 10:10 AM Staff F confirmed she entered rooms to ensure tenants breathed. Staff F explained Tenant C3 was often confused when she checked on him at night. He always thanked her for checking on him if she happened to wake him up. When completing his safety checks she would go all the way into his room and get close enough to ensure he was breathing.

Record review revealed Program Staff received training on how to perform Visual Checks on tenants. They were to enter a tenant's apartment and make visual contact whether the individual was awake or sleeping. They should document the visual check in the electronic system according to the time the check was required. The key was for the tenant to be viewed throughout the entire shift and ensure safety. At the end of the shift, ensure proper documentation was completed. Visual checks were meant to be completed as close to the scheduled time as possible. Falsification of documentation could lead to counseling and/or termination.

When interviewed on 4/27/26 at 3:40 PM the Assistant Director of Health and Wellness (ADHW) confirmed on 4/27/26 that staff should complete checks once every hour to confirm tenant location and status. The Program failed to ensure Tenant C3 and other memory care tenants received appropriate supervision when only one staff member worked. The ADHW confirmed during the time period when Tenant #3 died, Tenant C4 was into everything, Tenant #12

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was tearing down blinds and Tenant #2 would stay up all night. The scheduling of staff was not done properly. She worked a couple of overnight shifts and experienced how Tenant C4 and Tenant #2 would be in everything. She knew working alone in the secured memory care unit was a challenge.

The Program failed to ensure Tenant C3, and other tenants living in the secured memory care unit, received appropriate supervision when only one staff was working.

2. Record review revealed the Program completed a 90-day assessment for Tenant C3 on 11/14/25, which noted diagnoses including atherosclerotic heart disease, non-rheumatic mitral and aortic valve insufficiency, tachycardia, insomnia, neuropathy, lung nodule and lung pain. He required assistance with showering, medication administration, reminders to brush his dentures and reminders to attend meals. Tenant C3 wore TED hose with which he required assistance in putting on and removing each day. No behaviors were noted.

When interviewed on 5/6/26 at 9:15 AM a family member of Tenant C3, who was a medical professional, explained the family put a motion-activated camera in his apartment in November, 2025 after having concerns about whether he was receiving adequate care. Tenant C3 went to the emergency room (ER) and she visited 4-5 days later. The staff told her he wouldn't come out of his room and refused to eat. When she put her hands on his skin they were like dough with 4+ edema. She also found electrodes from the ER visit still attached to him. He was not wearing his TED hose and it took her 30 minutes to get them on. It made sense to her

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he was not leaving his apartment, as he would not have been able to walk with such swelling. She asked the staff to come to his apartment. Staff reported to her they did not know he was supposed to wear TED hose. When she watched video she saw staff were not entering his room every hour. She reported on 1/1/26, she saw video of Tenant C3 coming out of his bathroom at 2:38 AM. He then sat in a chair, let out a yelp and fell face down on the floor. He had intermittent movement from his feet for a short time before it stopped and he died. No one entered the apartment again until 7:00 AM.

During an interview with Tenant C3's daughter on 4/17/26 at 9:38 AM she expressed frustration with the care her father received at the Program. She had a camera in the apartment which allowed her to monitor the services he received. The daughter stated her father's legs were very swollen as he did not receive assistance with getting his TED hose put on daily. She sent multiple pairs of TED hose to the Program but the RN did not have the staff put them on him despite frequent requests for them to do so. Tenant C3 ' s daughter further noted he might go a week without a shower. It took her calling to complain to get things done. When she visited she might see staff sitting in the dining room talking or watching videos. His room was often filthy. She sent her father a lift chair for his birthday, but no one helped him to use it. One aide yelled at her father for sitting in the lift chair and turned it toward the wall so he was unable to use it. Another time he tried to stand up from his recliner and fell. He yelled for help. An aide came to his apartment and scolded him for yelling. She told him to be quiet because another tenant was dying.

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3) Record review on 4/21/25 of ER records dated 6/2/25 identified Tenant C7 was a 90-year-old female with a history of atrial fibrillation with a cardiac pacemaker in place, chronic kidney disease, diabetes and lower extremity edema. A review of a 90-day assessment dated 7/11/25 identified staff assisted Tenant C7 with bathing twice weekly. She required stand-by assistance with dressing. Staff were required to help her put on and take off her TED hose each day. She required wound care for weeping bilateral lower extremities, including twice-daily dressing changes.

A request for records was presented to local medical providers. Tenant C7 received the following care:
- On 7/17/25 she was referred to the ED by her cardiologist due to concerns including bilateral pedal edema with weeping and open areas. She had scattered superficial ulcerations to the distal tibia. Tenant C7 received IV Lasix and was discharged home.
- Tenant C7 returned to the ED on 7/28/25 due to concerns with weeping leg wounds and swelling. Tenant C7 was noted to have chronic peripheral edema on her bilateral legs. An examination of her skin showed skin with no significant erythema and no breakdown other than a superficial layer of maceration from wet wound dressings. Her wounds were cleansed and appropriately redressed. She was strongly encouraged to follow-up with her cardiologist and given the number for the wound clinic.

Tenant C7 received outpatient treatment at the Wound Care Clinic on 8/5/25 and 8/11/25. On 8/5/25, the Wound Care Clinic provided treatment orders to the Program as noted below:
-Wound #1 (Right and Left Lower leg wounds):

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clean with Skintegrity, cover with a single layer of Xeroform and gauze, use Soform wrap, tape and then mildly compress with Spandagrip. Ensure there are no wrinkles or rolling near the ends of the Spandigrip to avoid additional tissue injury. Change dressing every other day.
- Wound #2 to the right posterior thigh: Cut Xeroform to the size of the wound, fold gauze and use Medipore tape. Change dressing every other day.
- Wound #3 to the left and right heels: Apply Betadine to the blistered areas of the heels, then dry gauze. Keep feet elevated off bed. Keep pressure off the heels at all times. Change dressing daily.
- Wound #4 to the left 2nd toe: Betadine to cover the open area and weave dry gauze between the toes.

When interviewed on 4/17/26 at 2:05 PM Staff G explained she told a former nurse about Tenant C7's extreme weeping from the legs. There would be puddles on the floor from the fluid coming out of her legs. Tenant C7 would yell at Staff G and ask why she wouldn't wrap her legs. Staff trained in administering medication and treatments were the only ones who were supposed to apply the wrappings to Tenant C7's legs. Staff G did not have this training, but sometimes there wasn't anyone around to do this, so she would do it. She also reported the Program would run out of gloves, bandages or chux pads to complete Tenant C7's wound care.

When interviewed on 4/17/26 at 5:45 PM Staff B reported Tenant C7's legs would weep, clear up and then break open again. She had puddles of liquid in her room as a result of the pooling. This caused Tenant C7 pain. Staff B never received training on how to apply the bandages to her

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wounds. She discussed her concerns about the lack of training with the former nurse and Executive Director. She also told them about the lack of supplies such as gloves, gauze pads and gauze wraps, as they were out for about a month.

On 4/20/26 at 3:00 PM Staff H stated Tenant C7 was vocal about directing her on what treatment to apply to her legs. A co-worker, not a nurse, directed her on providing wound care to the tenant.

Staff I was interviewed on 4/27/26 at 2:45 PM and recalled Tenant C7's legs became red and moist. Her legs wept and she would leave a trail of fluid when she moved in her wheelchair. A co-worker trained her on how to apply the dressings to the tenant's legs. At times her legs were to be wrapped and other times they were to be left open.

There was no evidence the Program nurse sought care for Tenant C7 from her Primary Care Provider to address her swollen, weeping legs from 7/17/25 - 8/5/25. Staff were not adequately trained to address Tenant C7's needs. The program lacked the appropriate supplies to address Tenant C7's wounds according to staff interviews and there was no evidence the Program nurse reached out to others to obtain these supplies.

4) Record review on 4/22/26 revealed a Resident Information form identified Tenant #7 as a 92-year old woman with diagnoses of Alzheimer's disease, atherosclerotic heart disease of the native coronary artery with unspecified angina pectoris, occlusion and stenosis of the left carotid artery, aphasia following cerebral infarction, personal history of pulmonary embolism and

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essential hypertension. A December Medication Administration Record (MAR) for Tenant #7 revealed she was administered Nitroglycerin SL 0.4 mg on 12/26/25 at 8:43 PM. She received significant relief from the medication.

When interviewed on 4/15/26 at 1:50 PM Staff J recalled on 12/26/25 he entered the secured memory care unit around 9:00 PM and heard Tenant #7 yelling out. As he got closer, he saw she was sweating and pale. Tenant #7 said she had chest pains and was dizzy. She was sitting about 25 feet from Staff O and he was able to hear the tenant when he entered the unit from a distance of 300 feet. Tenant #7 was within eyesight of Staff O, although the employee was watching television on an electronic device. Staff J immediately assisted Tenant #7. He believed her blood pressure was 192/87, although this was not documented anywhere. He called the Assistant Director of Health and Wellness who directed him to administer Nitroglycerin SL 0.4 mg. Staff J gave Tenant #7 two to three tablets of Nitroglycerin SL. Staff O did not explain why she did not assist Tenant #7 or call for assistance.

When interviewed on 4/15/26 at 2:30 PM the ADHW reported hearing concerns from staff about Staff O coming to work and spending time on her tablet. Staff J called her to report the tenant's chest pain. She could not remember the tenant's vitals. When she came to the Program to follow up on this concern Staff O acted timid. The ADHW could not believe an employee would be on her tablet when a tenant was in distress.

5) Record review on 4/9/26 revealed Care History notes for Tenant #3 included the following entries:
- Tenant #3 had a small nose bleed on 1/20/26 at 1:20 PM but the bleeding continued through the

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afternoon so the tenant's daughter asked to transport her to Urgent Care for treatment; the ADHW called the Power of Attorney (POA), the tenant ' s other daughter, to see if this was acceptable and she agreed. The daughter called the Program at 5:45 PM and asked to take her mom home for the night. Program staff called the POA to ask for approval. The POA gave permission for the daughter to keep Tenant #3 at her home for the night.

- On 2/12/26, Tenant #3 ' s daughter took her mom out of the building without permission of the POA. The ADHW called the POA to make her aware.

- Tenant #3's POA requested the daughter no longer be allowed to visit her mother. It was noted on the tenant's notification page.

During an interview with Tenant #3 on 4/8/25 at 11:53 AM she reported her daughter (not the POA) used to visit, but no longer did so. She stated she would like her daughter to visit again.

On 4/9/26 at 9:10 AM Staff D was interviewed and recalled Tenant #3's daughters did not get along. Tenant #3's daughter used to visit all the time. She recalled hearing Tenant #3 stating the POA could not make all decisions for her and her other daughter was important to her as well.

Staff B was interviewed on 4/9/26 at 10:08 AM and believed Tenant #3 was depressed when her daughter was banned from the building. She knew there were times the daughter was disruptive in the building.

Tenant #3 and the Executive Director signed the Occupancy Agreement, Addendum D - Resident

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A 122	Continued From page 17 Bill of Rights on 9/26/24. The Bill of Rights included the right to associate and communicate privately and without restriction with persons of the resident's choice on the resident's initiative or on the initiative of the person at any reasonable hour. The State Long-Term Care Ombudsman developed a memo on 8/1/24 to address Visitation and Substitute Decision Makers. A Durable Power of Attorney was designated to make health care decisions. Visitation and access to a tenant was not a health care decision. Therefore, that right remained with the tenant. During a meeting with the ADHW on 4/8/25 at 1:15 PM she reported Tenant #3's daughter would come to the Program to see her mother. The daughter would yell while in the building and caused problems with the Hospice worker. The POA banned her sister from the building. 6. During an exit meeting with the Executive Director and ADHW on 4/28/26 at 11:30 AM they confirmed the Program failed to provide adequate and appropriate services to tenants as addressed above. The Executive Director and ADHW met with Tenant #3's daughter on 4/27/26 and made arrangements for her to begin meeting with her mother at the Program again.	A 122		
A 143	481-67.5(2)a Medications 481-67.5(231B,231C,231D) Medications. 67.5(2) Each program shall follow its own written medication policy, including the following:	A 143	**A 143 481-67.5(2)a Medications** **Corrective Action**: DHW will review residents requesting or appropriate for self/family medication administration and address each request according to policy. **Prevention**: Nursing and medication staff will be educated on tenant rights and the self-administration review process. **Monitoring**: DHW/designee will review medication self-administration requests weekly for 6 weeks, then monthly until 12/31/2026. **Correction Date**: 9/7/2026	

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A 143	Continued From page 18 a. The program will not prohibit a tenant from self-administering medications. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program prevented 1 of 10 current tenants reviewed from administering medication (Tenant #6). Findings follow: 1. Observation of a medication pass on 4/9/26 at 3:50 PM revealed Staff I alerted the Monitor to bottles of medication from the Veteran's Administration which belonged to Tenant #6. She reported these pills belonged to Tenant #6. When interviewed on 4/15/26 at 8:55 AM and 4/28/26 at 8:40 AM Tenant #6's daughter reported frustration with the Program due to the high number of medication errors. The daughter documented errors made by the program such as administering medication at the wrong time, not giving medication and not applying patches (which were used to treat dementia) in the right way. At each interview she explained how she asked the Assistant Director of Health and Wellness (ADHW) if she could administer her father's medication and was told this would be looked into. The daughter also asked for a meetings with the Executive Director ADHW but had not been granted one. 2. When interviewed on 4/22/26 at 9:35 AM Tenant #13 recalled a time when she had a terrible headache and asked the staff, who administered her medication, if she could have an aspirin. She was told she did not have any prescribed aspirin. The pain continued for several hours. Later a Med Tech told her she could have Tylenol and administered this to her.	A 143		

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A 143	Continued From page 19 Tenant #13 wondered why the first employee did not offer her Tylenol. She then asked the nurse if she could keep headache medication in her apartment to avoid this problem and was told she could not. A review of a Tenant List with cognitive scores provided by the Program on 4/8/26 showed Tenant #13 had a very mild cognitive decline. 3. Record review revealed the Program's Medication Services policy dated 6/13/24 noted the Executive Director would ensure the medication-related services required for or requested by each tenant would be provided. 4. During the exit meeting with the Executive Director and ADHW on 4/28/26 at 11:30 AM they confirmed they had not recently met with Tenant #6's daughter about her request to administer her father's medication. The Assistant Director of Health and Wellness said she would get an order from a tenant's primary care provider if a tenant or family wanted to administer their own medication. She had not approached either tenants' primary care provider about self or family administration.	A 143		
A 152	481-67.5(2)e(3) Medications 481-67.5(231B,231C,231D) Medications. 67.5(2)?Each program shall follow its own written medication policy, including the following: e. When medications are administered traditionally by the program: (3) Medications and treatments will be administered as prescribed by the tenant's	A 152	**A 152 481-67.5(2)E(3) Medications** **Corrective Action**: DHW or designee will complete a 100% medication order-to-MAR reconciliation and correct discrepancies, missing medications, and discontinued medications. **Prevention**: Medication staff will be re-educated on following provider orders, refill management, and new/discontinued orders. **Monitoring**: DHW/designee will audit 5 MARs weekly for 6 weeks, then monthly until 12/31/2026. **Correct Date**: 9/7/2026	

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A 152	Continued From page 20 physician, advanced registered nurse practitioner or PA. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review the Program failed to administer medication as prescribed for 7 of 10 tenants reviewed (Tenant #1, Tenant #2, Tenant #3, Tenant #4, Tenant #6, Tenant #8 and Tenant #9). Findings include but are not limited to: 1) Record review on 4/27/26 revealed admission orders for Tenant #6 (from an appointment on 1/14/26) noted he was scheduled to take medication which included: Docusate NA 100 mg. one capsule twice a day (stool softener), Melatonin 5 mg. take two capsules twice daily at bedtime (for insomnia), Tamsulosin HCL 0.4 mg. take one capsule at bedtime (for prostatic hyperplasia), Trazodone HCL 50 mg. take one tablet at bedtime (for insomnia), Metoprolol 25 mg. take one tablet every day (for blood pressure and heart rate) and Rivastigmine 9.5 mg. apply 1 patch daily (for memory). Tenant #6 moved into the Program on 2/17/26. A review of Tenant #6's February, 2026 Medication Administration Record (MAR) identified the following medication discrepancies: - Tenant #6 only received medication on the following days in February: 2/20, 2/24, 2/26, 2/27 and 2/28. - The Docusate NA was noted to only be administered as needed, not twice a day. Tenant #6 did not receive Docusate NA from staff in February. - Staff only gave Tenant #6 one 5 mg. pill (not two) of Melatonin on 2/24, 2/27 and 2/28.	A 152		

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- He received Tamsulosin at 7:00 AM instead of at bedtime.
- Trazodone was not listed on the MAR so he did not receive this medication (through April).

A review of the March, 2026 MAR identified the following issues:
- Docusate NA was changed on the MAR to a scheduled medication on 3/4, 100 mg. give two tablets at bedtime. However staff were unable to administer it 15 days as it was unavailable.
- The MAR was updated on 3/10 to direct staff to administer 10 mg. of Melatonin each night; he received 5 mg. of Melatonin from 3/1 - 3/9.
- Metoprolol was stopped on 3/4 and restarted on 3/11 for no clear reason.
- Tamsulosin was administered in the morning 3/1 through 3/23 and scheduled to evening administration on 3/24.

April:
- Cyanocobalamin was decreased from 1,000 mcg. to 500 mcg. on 4/6/26 according to a visit summary from that date. Staff continued to administer 1,000 mcg. through 4/16/26.

During interviews with Tenant #6's daughter on 4/15/26 and 4/28/26 she reported she believed the Program began administering her father's medication when he moved to the Program on 2/17/26. She handed them a bag of his pills on that date with the expectation they would begin administering his medication. The daughter was concerned about the number of mishaps with medication and documented these in her calendar. Her father wore a Risvastigmine patch which was applied to the skin once daily to treat dementia. Staff were to put a patch on her father's skin each day and then remove the old patch. There were many days she either found

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her father wearing two patches, no patch or a patch staff initialed and dated the previous day. The daughter provided her calendar in which she documented these errors as occurring on: 2/18/26, 2/19/26, 2/20/26 (not changed for three days), 2/26/26, 3/6/26, 3/10/26, 3/12/26 and 4/2/26. The daughter reported these concerns to the Assistant Director of Health and Wellness (ADHW).

2) Record review on 4/9/26 revealed a Resident Information sheet identifying Tenant #1 moved to the Program on 2/6/26. He was diagnosed with Diabetes Type II with diabetic polyneuropathy. Tenant #1 was hospitalized from 2/4/26 - 2/6/26 before his admission. One of the multiple medications listed on his 2/6/26 hospital After Visit Summary was Tresiba FlexTouch U-200, 200 unit/ml (3ml), concentrated injection pen, inject 120 units under the skin 1 time each day. There were no guidelines listed, such as not administering the medication when his blood glucose was high or low.

The RN completed a Resident Assessment and Care Plan which were signed by Tenant #1 on 2/6/26 noting he required assistance with administering insulin according to physician's orders.

A review of the February, 2026 MAR revealed staff did not begin administering medication to Tenant #1 until 2/10/26. A note indicated: Give daily, no sliding scale. Staff documented they did not administer the Tresiba to Tenant #1 as the Registered Nurse (RN) said to hold it until she reached the doctor. Tenant #1 was not administered his medication 21 times in February due to his blood glucose being too low, the RN

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directing staff to hold the medication or the medication not being available. Tenant #1 did not receive his Tresiba 16 times in March, 2026 per the MAR due to his blood sugar being too low.

Tenant #1 met with his Primary Care Provider (PCP) on 3/25/26. The PCP noted there was a lot of concern about his medication and whether he was getting his injectable medication. The RN reported he had been getting them; however, the patient did not think he was.

When interviewed on 4/21/26 at 10:10 AM Tenant 31 explained staff were supposed to administer his medication when he first moved in and they largely did so, however they did not give him his Tresiba on admission. They also wouldn't give him the Tresiba if his blood glucose was below 150. In the past, his doctor ordered him to take the Tresiba every day no matter what his blood glucose was. He is getting his Tresiba correctly now.

When interviewed on 4/9/26 at 9:10 AM Staff D explained when Tenant #1 first moved in the RN instructed staff not to administer Tresiba to him. The RN said she was going back and forth with the doctor about dosing instructions and whether it would cause his blood glucose to go low. The RN did not tell them when the issue was resolved. A few weeks ago the RN questioned her and asked why she wasn't administering the Tresiba every day.

On 4/9/26 at 10:08 AM Staff B reported there were no orders in the electronic MAR when Tenant #1 first moved to the Program on a Friday (2/6/26), although his medication was in the cart. They tried to call the RN but she did not answer the phone. The confusion with all of his

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medication was not resolved until the following Tuesday or Wednesday. She was told Tenant #1 should not receive his Tresiba if his blood glucose was under 150.

3) An observation of a medication pass on 4/8/26 at 3:50 PM with Staff I revealed there was no Pulmicort 90 mcg, an inhaler, for Tenant #3. Staff I reported the inhaler hadn't been refilled for a while. She believed Tenant #3 needed this medication because she suffered from symptoms of her asthma.

Record review on 4/9/26 of a Resident Information form revealed Tenant #3 was a 100-year-old woman on hospice diagnosed with unspecified asthma, glaucoma and gastro-esophageal reflux disease. It included orders for the following medication: Lantanaprost sol 0.005&, instill 1 drop in each eye once daily for glaucoma; Metamucil pak 4 in 1, 1 packet by mouth once daily for constipation; Pulmicort inhaler 90 mcg. inhale 1 puff twice daily for shortness of breath.

The March MAR identified she did not receive the following medication as listed:
- Lantanaprost eyedrops were only administered on 3/5, 3/7, 3/11, 3/12, 3/19 and 3/27. Other days the eyedrop was marked unavailable or not in the cart.
- Metamucil Pak 4 in 1, with a note the nurse was to reorder when needed, was only administered on 3/7, 3/11, 3/12 and 3/27. Other days Metamucil was marked not in cart, not available or unavailable.
- Pulmicort Inhaler was documented as not in cart by staff beginning on 3/20. Tenant #3 missed 18 doses of Pulmicort.

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A 152	Continued From page 25 The surveyor asked the Assistant Director of Health and Wellness about the status of Tenant #3's refills on 4/9/26 at 2:15 PM. She reported she would check. The surveyor followed up on the status of Tenant #3's Pulmicort on 4/16/26 at 9:10 AM. The ADHW said she did not have an opportunity to check on this. 4) On 4/28/26 at 7:50 AM during a medication pass Staff L noted there were two medication cards of Glipizide 10 mg. (one card for morning, one card for evening) in the cart for Tenant #9, but this medication was discontinued over a week ago. Staff L reported she put sticky notes on these cards on 4/25/26 informing her co-workers the medication was not on the MAR. Staff L was able to pull up a list of discontinued medication orders for Tenant #9. The Glipizide started on 4/2/26 and was discontinued on 4/16/26. The morning Glipizide card was missing pills from the 4/17, 4/18, 4/19, 4/20, 4/21, 4/22, 4/23, 4/24 and 4/27 spots. The evening Glipizide card was missing tablets from the 4/16, 4/17, 4/18, 4/19, 4/20, 4/21, 4/23, 4/24 and 4/27 spots indicating they were administered. A review of Tenant #9's 4/28/26 Resident Information sheet, which listed her current medication orders, did not include the medication Glipizide. An exit meeting was held on 4/28/26 at 11:30 with the Executive Director and ADHW. The ADHW stated she would focus on ensuring tenants' medication orders were correct following the recertification visit.	A 152		

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A 191	Continued From page 26 481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure there were a sufficient number of properly trained staff available to ensure the safety of 5 of 10 current tenants reviewed (Tenant #2, Tenant #3, Tenant #4, Tenant #6 and Tenant #8), 3 of 7 discharged tenants reviewed (Tenant C3, Tenant C4 and Tenant C7) and potentially affecting all tenants. Findings include, but are not limited to: 1) Record review on 4/13/26 revealed an Internal Occurrence Report form for Tenant C3 dated 1/1/26 at 7:05 AM. Staff entered Tenant C3's apartment and found him face down on the floor with his head toward the bathroom. He had blood around his head and no pulse; his skin was cold and his body was stiff. Record review revealed Tenant C3's death certificate noted the cause of death as cardiopulmonary arrest. On 12/30/25, the Nurse Practitioner noted Tenant C3 was a 96-year-old male with dementia, agitation, and anxiety. A daily task sheet from 12/31/25, 10:00 PM - 1/1/26, 6:00 AM, required 8 hourly safety checks. Staff C worked in the secured memory care unit and documented hourly checks from 2200 (10:00 PM) through 4:44 AM.	A 191	**A 191 481-67.9(1) Staffing** **Corrective Action**: ED/DHW will review census, acuity, service needs, and staffing and adjust schedules as needed to meet resident needs. **Prevention**: Staffing levels will be reviewed routinely and with changes in census, acuity, or resident needs. **Monitoring**: ED/designee will review staffing and missed/delayed care weekly for 6 weeks, then monthly until 12/31/2026. **Correct Date**: 9/7/26	
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A 191	Continued From page 27 When interviewed on 4/23/26 at 10:06 AM Staff C stated she worked alone in the memory care unit on 12/31/25 - 1/1/26. She could not recall the last time she checked on Tenant C3 before leaving on 1/1/26. She documented her tasks at 4:44 AM, but stated this reflected the time she completed documentation, not the time of the check. Staff C reported she hesitated to enter apartments where tenants slept because of high needs, including wandering. She reported she had to break up fights and keep others from tearing up items in their rooms such as the air conditioning unit. Almost all of the tenants were at risk of falling. She begged the Executive Director to staff two employees in the memory care unit at night. When two staff were present, they were able to provide safety checks to tenants as required. During an interview with Staff J on 4/27/26 at 2:00 PM he reported he arrived for his shift at 6:00 AM on 1/1/26, and entered Tenant C3's apartment between 6:30 AM and 7:00 AM. He confirmed staff must fully visualize tenants during safety checks. When interviewed on 4/15/26 at 10:10 AM Staff F confirmed she entered rooms to ensure tenants breathed. Staff F explained Tenant C3 was often confused when she checked on him at night. He always thanked her for checking on him if she happened to wake him up. When completing his safety checks she would go all the way into his room and get close enough to ensure he was breathing. Record review revealed Program Staff received training on how to perform Visual Checks on tenants. They were to enter a tenant's apartment and make visual contact whether the individual	A 191		

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was awake or sleeping. They should document the visual check in the electronic system according to the time the check was required. The key was for the tenant to be viewed throughout the entire shift and ensure safety. At the end of the shift, ensure proper documentation was completed. Visual checks were meant to be completed as close to the scheduled time as possible. Falsification of documentation could lead to counseling and/or termination.

When interviewed on 4/27/26 at 3:40 PM the Assistant Director of Health and Wellness (ADHW) confirmed on 4/27/26 that staff should complete checks once every hour to confirm tenant location and status. The Program failed to ensure Tenant C3 and other memory care tenants received appropriate supervision when only one staff member worked. The ADHW confirmed during the time period when Tenant #3 died, Tenant C4 was into everything, Tenant #12 was tearing down blinds and Tenant #2 would stay up all night. The scheduling of staff was not done properly. She worked a couple of overnight shifts and experienced how Tenant C4 and Tenant #2 would be in everything. She knew working alone in the secured memory care unit was a challenge.

2) A review of task sheets and Resident Assessments identified services tenants were supposed to receive compared with what they did receive from 4/1/26 - 4/15/26. The tenants lived on the secured memory care unit and received hourly safety checks. Examples included the following:

a. The Resident Assessment for Tenant #2 dated 2/5/26 revealed she required assistance with

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bathing, dressing, oral care and toileting four times daily and as needed. The program provided laundry services every Wednesday and housekeeping each Tuesday.
- 4/1/26: Staff documented providing dressing, oral care, toileting and safety checks at 4:51 AM. No other tasks were noted for the rest of the day.
- 4/2/26: The documentation of dressing, oral care, toileting, safety checks and socialization was done between 8:14 PM - 8:20 PM. Staff did not note they provided cares earlier in the day.
- 4/15/26: Staff documented for the day between 1:58 PM - 2:09 PM noting they assisted Tenant #2 with toileting three times, dining reminders twice and provided mobility assistance twice.
- There were no entries for bathing assistance, laundry or housekeeping.

b. Tenant #3 had a care plan dated 2/13/26. Staff were to assist her with a bath one time weekly, dressing/undressing, oral care, toileting assistance every two hours, dining reminders, daily bed making, once weekly housekeeping and laundry on Tuesday.
- 4/1/26: Between 3:38 AM and 5:21 AM staff documented they provided toileting assistance six times. She received no other toileting assistance throughout the rest of the day.
- 4/2/26: Staff made three entries on the task sheet for providing toileting assistance to Tenant #3 at 4:55 AM.
- 4/3/26: Staff documented Tenant #3 refused assistance with toileting (twice), oral care, hearing aids and dressing between 3:02 AM - 3:06 AM, an unusual time to assist individuals with these tasks.
- 4/12/26: The only cares documented were toileting assistance (twice) at 5:13 AM.

c. Tenant #6 had a Resident Assessment dated

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3/11/26. He required staff assistance with bathing, dressing, grooming, oral care, weekly housekeeping and weekly laundry.
- 4/1/26: Staff documented assistance with oral care and eyewear at 4:53 AM.
- 4/12/26, 4/14/26: no entries for any cares provided.
- There were no entries for dressing, grooming, laundry or housekeeping on any of Tenant #6's task sheets. He received one bath on 4/15/26.

3) Review of a Device Activity Report dated 4/8/26 - 4/15/26 revealed the following:
- Tenant #14 waited for assistance for 20 minutes on 4/14 at 4:41 PM, 17 minutes on 4/13 at 9:24 AM, 27 minutes on 4/13 at 8:25 AM, 21 minutes of 4/13 at 12:15 AM, 21 minutes on 4/10 at 12:40 PM, 20 minutes on 4/10 at 11:43 AM and 17 minutes on 4/10 at 8:08 AM.
- Tenant #8 waited for help from staff after pushing her pendant for 23 minutes on 4/14 at 4:36 PM, 28 minutes on 4/14 at 5:42 PM and 46 minutes on 4/13.
- Tenant #4 waited 18 minutes for assistance on 4/9 and 27 minutes on 4/8.

When interviewed on 4/15/26 at 8:40 AM Tenant #14 explained at her age of 103 she received assistance with most activities of daily living. The primary reason she pushed her pendant was to go to meals and to the bathroom. There were times staff responded promptly and other times it took a long time. When she was waiting a long time for staff to assist her to the bathroom this could be problematic and she might get up and go by herself. Tenant #14 believed the staff did their best but they were stretched too thin.

During an interview with Tenant #4 on 4/28/26 at 9:15 AM he reported he pressed his pendant for

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staff assistance with cares such as his colostomy and blood sugars. Tenant #4 had low blood glucose readings at times which required staff to call the ambulance. At the time of the interview, he was waiting for staff help him with a shower. He was supposed to receive one twice a week and the last one he got was on 4/20/26.

When interviewed on 4/14/26 at 7:15 PM, Staff E reported the staff used to carry devices and would immediately know when a tenant pushed the call light. They no longer had this system. Now the staff had to go to the break room and look at a master computer to know when a tenant pushed their pendant. If they were busy in a tenant's apartment, it could take 20-25 minutes before they were able to check the status of the call lights. With the new system, a tenant could be sitting an extra 5, 6, 7 minutes waiting for staff to respond because they had to walk to the break room to check the computer rather than receive an immediate notification. There were also times when they could not get everyone's showers completed because there weren't enough staff working. Staff E worried about the times when she was the only person in the building trying to administer medication to tenants within the time parameters while also responding to pendants and providing their cares. She felt as if this was a safety concern.

On 4/13/26 at 10:35 AM Staff L stated she had no way of knowing a tenant's pager sounded until she went to the break room and saw it on the computer. She knew pagers were not answered within 15 minutes. On 4/10/26 she worked with one other employee and knew they did not respond to tenant's calls in a timely manner. She was concerned about the lack of staffing as there was often only one employee working in the

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dementia unit.

The Assisted Living Residency Agreement noted activating an emergency call system did not necessarily mean an immediate response, but as soon as practical. When a tenant requested non-emergency assistance, they would respond with the goal of meeting the needs of the tenant. The tenant acknowledged staff may not immediately respond to the request if they were providing care to others.

4) The Program provided an Entrance form on 4/8/26 which noted the staffing patterns for the building were 3 employees working in the general population unit each 12 hour shift and 2 employees working in the dementia unit each shift. There were 50 tenants living on the general population unit and 17 tenants living on the dementia unit.

A review of employee time card reports revealed on Monday, 4/6/26 from 6:00 AM - 6:00 PM there was one employee who worked the 12 hour shift. 2 employees worked from 6:00 AM - 2:00 PM.

On 4/10/26, during the 6:00 AM - 6:00 PM shift, one employee worked 6:01 AM - 2:05 PM, another employee worked 4:54 AM - 6:12 PM. The Director of Sales and Director of Celebrations were also on-shift.

During an interview with Staff B on 4/9/26 at 10:08 AM she reported 4/6/26 was one of the hardest days she experienced at work. She didn't finish with the morning medication pass until 11:00 AM, even though most of the tenants' medication should have been administered by 9:00 AM. There weren't enough staff in the building to get the needed tasks completed on

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time.

Tenant #6's daughter was interviewed on 4/15/26 at 8:55 AM and 4/28/26 at 8:40 AM and reported she was concerned about the lack of staffing. When she moved her father to the secured memory care unit in February, 2026 she was assured there would be two staff present at all times. There have been a number of mistakes including medication errors and falls. The daughter felt the need to stay with her father most days due to concerns for her father and the other tenants. She gave her father a shower after he hadn't received one for 10 days. She left her father's laundry out in the hall for 4 days after his laundry day waiting for the employees to wash it but they had not done so.

When interviewed on 4/15/26 at 11:45 AM the Director of Sales reported she occasionally helped out on the floor when they were short staffed. She was never trained to do cares, but she would help transfer tenants and bring them to/from meals. When tenants moved to the Program she promised them they would be safe and felt an obligation to do these things when there weren't enough staff working the floor.

During an interview with the Director of Celebrations on 4/14/26 at 12:30 PM she explained she helped work the floor on 4/10/26 because of a lack of staff. She was delegated several years ago by a previous nurse. The Program had been short-staffed for quite some time in her opinion.

An exit interview was conducted on 4/28/26 at 11:30 AM during which the Executive Director and ADHW confirmed the building lacked the necessary staff to meet the needs of tenants.

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A 191	Continued From page 34 They made the decision to bring in additional staff through a temporary agency to fill in the gap. The ADHW also had plans to ensure all staff were adequately trained to meet the needs of tenants.	A 191		
A 195	481-67.9(4)a Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall include the following: a. The program's newly hired nurse will within 60 days of beginning employment as the program's nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program's Registered Nurse failed to ensure 3 of 4 staff reviewed were properly trained within 60 days of her hire date. Findings follow: Record review on 4/15/26 revealed the Program had a Registered Nurse (RN) working in the building from 8/13/25 - 4/1/26. The RN was responsible for the delegation of certified and noncertified staff. Staff C was hired to work at the Program as a Care Manager on 6/5/25. Signed delegations were unavailable for Staff C. Staff E was hired to work at the Program as a	A 195	**A 195 481-67.9(4)a Staffing** **Corrective Action**: DHW or designee will audit all current staff delegation and competency records and complete missing requirements. **Prevention**: A tracking system will be maintained for staff training, competency, delegation, and renewal dates. **Monitoring**: DHW or designee will review the tracker weekly for 6 weeks, then monthly until 12/31/2026. **Correction Date**: 9/7/26	

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A 195	Continued From page 35 Med Tech on 5/19/23. She was delegated on 3/7/24 by a previous RN. She had not been delegated by the current RN. Staff F was hired to work at the Program as a Care Manager on 4/29/25. Signed delegations for Staff F were unavailable. During an exit meeting held on 4/28/26 at 11:30 AM the Executive Director and Assistant Director of Health and Wellness confirmed the Program did not ensure staff were properly trained.	A 195		
A 200	481-67.9(4)f Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4)?Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall include the following: f. Services will be provided to tenants in accordance with the training provided. This REQUIREMENT is not met as evidenced by: Based on interview and record review Program staff failed to receive adequate training when providing services to 1 of 10 current tenants reviewed (Tenant #4) and 1 of 8 discharged tenants reviewed (Tenant C7). Findings follow: 1) Record review on 4/23/26 of notes from the Wound Care Center dated 8/5/25 and 8/11/25 revealed Tenant C7 was referred to the wound center by a nurse at the Program. She spent much of her time sitting in a wheelchair which	A 200	**A200 481-67.9(4)f Staffing** **Corrective Action**: DHW or ADHW will verify staff performing specialized treatments are properly trained and competent. **Prevention**: Staff will not perform delegated or specialized services without documented nurse training and competency. **Monitoring**: DHW or ADHW will audit 5 delegated services weekly for 6 weeks, then monthly until 12/31/2026. **Correct Date**: 9/7/26	

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resulted in her legs being wet, weeping and having multiple open wounds. Following treatment at the clinic, Tenant C7 returned to the Program with the following instructions on 8/5/25:
-Wound #1 (Right and Left Lower leg wounds): clean with Skintegrity, cover with a single layer of Xeroform and gauze, use Soform wrap, tape and then mildly compress with Spandagrip. Ensure there are no wrinkles or rolling near the ends of the Spandigrip to avoid additional tissue injury. Change dressing every other day.
- Wound #2 to the right posterior thigh: Cut Xeroform to the size of the wound, fold gauze and use Medipore tape. Change dressing every other day.
- Wound #3 to the left and right heels: Apply Betadine to the blistered areas of the heels, then dry gauze. Keep feet elevated off bed. Keep pressure off the heels at all times. Change dressing daily.
- Wound #4 to the left 2nd toe: Betadine to cover the open area and weave dry gauze between the toes.

During an interview with Staff G on 4/17/26 at 2:05 PM she explained she told a former nurse about Tenant C7's extreme weeping from the legs. There would be puddles on the floor from fluid coming out of her legs. Tenant C7 would yell at Staff G and ask why she wouldn't wrap her legs. Staff who were trained in administering medication and treatments were supposed to apply the wrappings to Tenant C7's legs. Staff G did not have this training, but sometimes there wasn't anyone around to do this, so she would do it. The biggest problem when completing Tenant C7's wound care was when they ran out of gloves, bandages or chux pads.

When interviewed on 4/17/26 at 5:45 PM Staff B

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reported Tenant C7's legs would weep, clear up and then break open again. She had puddles of liquid in her room as a result of the pooling. This caused Tenant C7 pain. She never received training on how to apply the bandages to her wounds. She discussed her concerns about the lack of training with the former nurse and Executive Director. She also told them about the lack of supplies such as gloves, gauze pads and gauze wraps. They were out for about a month.

On 4/20/26 at 3:00 PM Staff H stated Tenant C7 was vocal about directing her on what to do with her legs. A co-worker, not a nurse, directed her on providing wound care to the tenant.

Staff I was interviewed on 4/27/26 at 2:45 PM and was able to remember Tenant C7's legs would get red and moist. Her legs wept and she would leave a trail of fluid when she moved in her wheelchair. A co-worker trained her on how to perform the wrappings to the tenant's legs. At times her legs were to be wrapped and other times they were to be left open.

During an exit meeting with the Executive Director and Assistant Director of Health and Wellness on 4/28/26 at 11:30 AM they confirmed staff should have received training specific to Tenant C7's wound care needs.

2) Record review of a Resident Assessment for Tenant #4 dated 3/18/26 identified he required set up to manage his colostomy daily at 7:00 AM, 8:00 PM and as needed. Staff were to encourage him to burp and empty his colostomy. He also required assistance with the administration of insulin.

During an interview with Tenant #4 on 4/28/26 at

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A 200	Continued From page 38 10:00 AM he stated there were 3 employees who worked at the Program who were trained and willing to assist him with emptying his colostomy bag. If these employees weren't working, he was largely able to manage the task on his own. On 4/27/26 at 2:45 PM Staff I was interviewed and stated she was not trained on providing colostomy cares so she did not touch Tenant #4's pouch. When interviewed on 4/27/26 at 2:00 PM Staff J reported being trained by a former co-worker on how to empty a colostomy bag. A nurse did not provide this training to him. Staff B was interviewed on 4/9/26 at 10:08 AM and reported being trained by a former employee on how to manage his colostomy. She was not trained by a nurse. Tenant #4 used insulin. There were times when the pharmacy sent a vial of insulin rather than an insulin pen. She had to draw up his insulin into syringes at times but was previously told this was not acceptable. On 4/9/26 at 9:10 AM Staff D reported she drew up insulin into a syringe from a vial when his insulin pen was not available. The Assistant Director of Health and Wellness reported on 4/28/26 at 11:30 AM only nursing staff were able to draw up insulin, not Staff B or Staff D. She confirmed staff needed to receive training on caring for a tenant's colostomy and specialized wound care.	A 200		
A 201	481-67.9(4)g Staffing 481-67.9(231B,231C,231D) Staffing.	A 201	**A201 481-67.9(4)g Staffing** **Corrective Action**: DHW or designee will implement a process for documenting, reviewing, acting on, and retaining staff change-of-condition reports. **Prevention**: Staff will be educated on what must be reported, documented, and submitted to nursing. **Monitoring**: DHW or designee will audit reports weekly for 6 weeks, then monthly until 12/31/26. **Correct Date**: 9/7/26	

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67.9(4)?Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall include the following:

g. The program will have in place a system by which direct care staff communicate in writing occurrences that differ from the tenant's normal health and functional and cognitive status. The program's nurse or designee will train staff on reporting to the program's nurse(s) or designee(s) and documenting occurrences that differ from the tenant's normal health and functional and cognitive status. The written communication required by this paragraph will be retained by the program for a period of not less than three years and be accessible to the department upon request.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the Program failed to retain copies of the Staff Documentation/Communication to the Registered Nurse forms. Findings follow:

The Program was unable to produce Staff Documentation/Communication to the Registered Nurse forms when requested on 4/15/26.

When interviewed on 4/15/26 at 10:05 AM, Staff A produced 33 Staff Documentation/Communication to RN forms. Staff A stated she made copies of the forms after she submitted them to the nurse due to her concerns the nurses at the building were not acting on her reports or retaining the forms.

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A 201	Continued From page 40 During an interview with Staff B on 4/21/26 at 1:00 PM she explained she kept copies of the Staff Documentation/Communication to RN forms. Staff B provided 9 copies of forms she submitted to the RN in the past. She stated an administrator suggested she do this. The Assistant Director of Health and Wellness (ADHW) reported staff filled out the forms and she would take care of the matter the following day. She did not retain the forms.	A 201		
A 307	481-67.18(3) Record Checks 481-67.18(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.18(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall complete the background check requirements set forth below. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure a complete background check was completed for 1 of 6 employees reviewed (Staff K). Findings follow: Record review on 4/9/26 of a Single Contact License and Background Check for Staff K dated 1/30/26 found the Program failed to obtain a child abuse record. She started working at the Program on 2/5/26. During an interview with the Executive Director on 4/9/26 at 12:45 PM he confirmed the Program	A 307	**A 307 481-67.18(3)** **Record Checks** **Corrective Action**: ED/BOM will audit current employee files for required background checks and correct any deficiencies. **Prevention**: All required background checks will be completed before employment begins. **Monitoring**: ED/designee will audit 100% of new-hire files weekly for 6 weeks. **Correct Date**: 9/7/26	

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A 307	Continued From page 41 failed to obtain Staff K's child abuse history prior to her date of hire. When he was made aware of this failure, he completed a new background check on 4/9/26 which showed no history of child abuse.	A 307		
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 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 use the Global Deterioration Scale (GDS) when completing the Resident Assessment for 1 of 1 tenants reviewed with cognitive impairment who lived there more than three months (Tenant #2). Findings follow: Record review on 4/9/26 of a Resident Information form revealed Tenant #2 moved to the Program on 12/15/23 and carried a diagnosis of unspecified dementia. A Change in Condition Resident Assessment was completed on 2/5/26, including a health and functional evaluation. Within the assessment was a section for a cognitive evaluation.	A 232	**A 232 481-69.22(3)** **Evaluation of Tenant** **Corrective Action**: DHW or designee will review residents whose cognitive screening indicates moderate cognitive decline and risk and complete the GDS where required. **Prevention**: Clinical staff will be re-educated on use of a scored cognitive screening tool and when results require use of the GDS at subsequent evaluations. **Monitoring**: DHW or designee will audit 5 cognitive assessments weekly for 6 weeks, then monthly until 12/31/2026. **Correct Date**: 9/7/26	

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A 232	Continued From page 42 On 10/9/25 a clinician assessed Tenant #2 and determined she was unable to complete the SLUMS (a brief screening test for detecting dementia) and the GDS was required. There was no evidence the GDS was completed on 10/9/25 or 2/5/26. During an interview with the Assistant Director of Health and Wellness on 4/8/26 at 12:25 PM she reported the only cognitive assessments completed by Program staff were the SLUMS, they did not use the GDS, even for tenants with moderate cognitive impairment.	A 232		
A 268	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure nurse's notes and wound care orders were retained by the program for 1 of 8 discharged tenants reviewed (Tenant C7). Findings follow: Record review on 4/20/26 revealed there were no	A 268	**A 268481-69.25(1)i** **Tenant Documents** **Corrective Action**: DHW or designee will review current records to ensure provider orders, nursing notes, and treatment records are complete and retrievable. **Prevention**: Clinical staff will be educated on receipt, implementation, and retention of clinical documentation. **Monitoring**: DHW or designee will audit 5 records weekly for 6 weeks, then monthly until 12/31/2026. **Correct Date**: 9/7/26	

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nursing notes for Tenant C7 after 4/1/25. There were no orders from the wound clinic after 5/8/25, at which time she discharged from wound care services.

Review of a 90-day assessment dated 7/11/25 identified staff assisted Tenant C7 with bathing twice weekly. She required stand-by assistance with dressing. Staff were required to help her put on and take off her TED hose each day. Tenant C7 required assistance for dressing changes to her wounds. She had weeping to her bilateral lower extremities. Dressings were applied each morning and night and as needed. The areas were washed with warm soapy water, patted dry and a new absorbent bandage was replaced on the wound.

A request for records was presented to local medical providers. Tenant C7 received the following care:
- She went to the Emergency Room (ER) on 6/2/25 for evaluation of increased swelling in the lower extremity and shortness of breath which was ongoing for the past several days. On physical exam, the physician noted bilateral chronic venous stasis dermatitis changes with pitting edema and a superficial skin wound to the left anterior leg with surrounding erythema. She was given an antibiotic and encouraged to limit her fluids.
- On 7/17/25 she was referred to the ER by her cardiologist due to concerns including bilateral pedal edema with weeping and opened areas. Tenant C7 had chronic leaking fluid from the lower extremities. She had scattered superficial ulcerations to the distal tibia. Tenant C7 received IV Lasix and was discharged home.
- Tenant C7 went to the ER on 7/28/25 due to concerns with leg wounds which were weeping

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and swollen. Her heels were painful. Tenant C7 was noted to have chronic peripheral edema on her bilateral legs. An examination of her skin showed skin with no significant erythema and no breakdown other than a superficial layer of maceration from wet wound dressings. Her wounds were cleansed and appropriately redressed. She was strongly encouraged to follow-up with her cardiologist and given the number for the wound clinic.
- She received outpatient treatment at the Wound Care Clinic on 8/5/25 and 8/11/25. The clinic provided treatment orders to the Program.
- On 8/17/25 she fell out of bed and injured her right knee. She was diagnosed with periprosthetic fracture around an internal prosthetic on the right side. Tenant C7 was advised to wear a knee immobilizer and could bear weight as tolerated with her walker.
- Tenant C7 returned to the ED on 8/17/25 after being unable to control the pain in her right knee. She was discharged back to the program earlier in the morning. She was unable to bear weight due to the acute pain. Staff at the program reported she require the assistance of 2 or more staff to assist her and she exceeded their care abilities. She discharged to a skilled nursing facility and did not return.

A review of Tenant C7's record revealed no physician's orders for the treatments which were noted in the 90-day assessment. There were no nursing notes regarding the emergency room visits, wound clinic visits, hospitalization or discharge.

The Executive Director and Assistant Director of Health and Wellness confirmed these records were not in Tenant C7's record during an exit interview on 4/28/26 at 11:30 AM. They reported

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A 268	Continued From page 45 some of the records were not available as the Program switched from one electronic record system to a different electronic record system. One of the previous nurse's may have downloaded tenant records but they did not know where the records were located.	A 268		
A 274	481-69.25(1)o Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports need not be included in the tenant's medical record); This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to document medication errors involving 7 of 10 tenants reviewed and potentially all tenants (Tenant #1, Tenant #2, Tenant #3, Tenant #4, Tenant #6, Tenant #8 and Tenant #9). Findings include but are not limited to: 1) Record review on 4/27/26 of admission orders for Tenant #6 revealed he was scheduled to take medication, including: Docusate NA 100 mg. one capsule twice a day (stool softener), Melatonin 5 mg. take two capsules twice daily at bedtime (for insomnia), Tamsulosin HCL 0.4 mg. take one capsule at bedtime (for prostatic hyperplasia),	A 274	**A274 481-69.25(1)o Tenant Documents** **Corrective Action**: DHW or designee will review medication variances and ensure required medication error reports and notifications are completed. **Prevention**: Medication staff will be re-educated on what constitutes a medication error and required reporting. **Monitoring**: DHW or designee will review MAR exceptions and medication errors weekly for 6 weeks, then monthly until 12/31/2026. **Correct Date**: 9/7/26	

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Trazodone HCL 50 mg. take one tablet at bedtime (for insomnia) and Metoprolol 25 mg. take one tablet every day (for blood pressure and heart rate). Tenant #6 moved into the Program on 2/17/26.

A review of the February, 2026 Medication Administration Record (MAR) identified the following discrepancies:
- Staff documented they only administered medication to Tenant #6 on the following days: 2/20, 2/24, 2/26, 2/27 and 2/28.
- The Docusate NA was noted to only be administered as needed, not twice a day. Staff did not provide the medication to Tenant #6 throughout the month.
- Staff only gave Tenant #6 one 5 mg. pill of Melatonin on 2/24, 2/27 and 2/28.
- He received Tamsulosin at 7:00 AM instead of at bedtime.
- Trazodone was not listed on the MAR so he did not receive this medication (through April).

A review of the March, 2026 MAR identified the following issues:
- Docusate NA was changed on the MAR to a scheduled medication on 3/4/26, 100 mg. give two tablets at bedtime. However staff were unable to administer it 15 days as it was marked unavailable.
- The MAR was updated on 3/10/26 to direct staff to administer 10 mg. of Melatonin each night.
- Metoprolol was stopped on 3/4/26 and restarted on 3/11/26.
- Tamsulosin was administered in the morning through 3/23/26 and rescheduled to evening administration on 3/24/26.

In April:
- Cyanocobalamin was decreased from 1,000 mcg. to 500 mcg. on 4/6/26. Staff continued to

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administer 1,000 mcg. through 4/16/26.

Throughout the month of March, staff documented medication was not administered to Tenant #6 (not available in cart, med not available, med tech got in at 6, already popped, etc.) 60 times. Documentation on the April, 2026 MAR indicated from 4/1/26 - 4/15/26 Tenant #6 did not receive 16 pills for reasons marked as other or medication not available.

During interviews with Tenant #6's daughter on 4/15/26 and 4/28/26 she reported she believed the Program began administering her father's medication when he moved to the Program on 2/17/26. She handed them a bag of his pills on that date with the expectation they would begin administering his medication. The daughter was concerned about the number of mishaps with medication and documented these in her calendar. Her father wore a Risvastigmine patch which was applied to the skin once daily to treat dementia. Staff were to put a patch on her father's skin each day and then remove the old patch. There were many days she either found her father wearing two patches, no patch or a patch staff initialed and dated the previous day. The daughter showered her calendar in which she documented these errors as occurring on: 2/18/26, 2/19/26, 2/20/26 (not changed for three days), 2/26/26, 3/6/26, 3/10/26, 3/12/26 and 4/2/26. The daughter reported these concerns to the Assistant Director of Health and Wellness who said she would document the errors. She asked for a copy of the medication error forms but had not received them.

2) Record review on 4/9/26 revealed a Resident Information sheet identifying Tenant #1 moved to the Program on 2/6/26. He was diagnosed with

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A 274	Continued From page 48 Diabetes Type II with diabetic polyneuropathy. Tenant #1 was hospitalized from 2/4/26 - 2/6/26 before his admission. One of the multiple medications listed on his 2/6/26 After Visit Summary was Tresiba FlexTouch U-200, 200 unit/ml (3ml), concentrated injection pen, inject 120 units under the skin 1 time each day. There were no guidelines listed as to not administering the medication when his blood glucose was high or low. The Registered Nurse (RN) completed a Resident Assessment and Care Plan which were signed by Tenant #1 on 2/6/26 noting he required assistance with administering insulin according to physician's orders. A review of the February, 2026 MAR revealed staff did not begin administering medication to Tenant #1 until 2/10/26. A note indicated: Give daily, no sliding scale. Staff documented they did not administer the Tresiba to Tenant #1 as the RN said to hold it until she got reached the doctor. Tenant #1 was not administered his medication 21 times related to his blood glucose being too low, the RN directing staff to hold the medication or medication not being available. Tenant #1 did not receive his Tresiba 16 times in March, 2026 per the MAR due to his blood sugar being too low. Tenant #1 met with his Primary Care Provider (PCP) on 3/25/26. The PCP noted there was a lot of concern about his medication and whether he was getting his injectable medication. The RN reported he has been getting them. However the patient does not think he is. Tenant #1 was interviewed on 4/21/26 at 10:10 AM. He reported staff were supposed to	A 274		

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administer his medication when he first moved in and they largely did so. They did not give him his Tresiba at first. They also wouldn't give him the Tresiba if his blood glucose was below 150. In the past, his doctor ordered him to take the Tresiba every day no matter what his blood glucose was. He was getting his Tresiba correctly now.

Staff D was interviewed on 4/9/26 at 9:10 AM and explained when Tenant #1 first moved in the RN instructed staff not to administer Tresiba to him. The RN said she was going back and forth with the doctor about dosing instructions and whether it would cause his blood glucose to go low. The RN did not tell them when the issue was resolved. A few weeks ago the RN questioned her and asked why she wasn't administering the Tresiba every day.

Staff D found pills on the floor in tenants' apartments. She identified two tenants she reordered medications for which had not been filled. The tenants were going without the medication. She reported these concerns to the building nurses. Staff D was not directed to complete medication error forms.

On 4/9/26 at 10:08 AM Staff B reported there were no orders in the electronic MAR when Tenant #1 first moved to the Program on a Friday (2/6/26), although his medication was in the cart. They tried to call the RN but she did not answer the phone. The confusion with all of his medication was not resolved until the following Tuesday or Wednesday. She was told Tenant #1 should not receive his Tresiba if his blood glucose was under 150.

Staff B found pills in tenants rooms. She believed

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getting refills on time for tenants was an issue. Staff B knew of two tenants who went part of a day without insulin. One tenant had two medication patches on her at one time. Staff B was never provided information about completing medication error forms.

3) An observation of a medication pass on 4/8/26 at 3:50 PM with Staff I revealed there was no Pulmicort 90 mcg. available for Tenant #3. Staff I reported this medication was not refilled for a long time. She believed Tenant #3 needed this medication due to symptoms of asthma.

Record review on 4/9/26 of a Resident Information form revealed Tenant #3 was a 100-year-old woman on hospice diagnosed with unspecified asthma, glaucoma and gastro-esophageal reflux disease. The March MAR identified she did not receive the following medication as listed:
- Lantanaprost eyedrops were only administered on 3/5, 3/7, 3/11, 3/12, 3/19 and 3/27. Other days the eyedrop was marked unavailable or not in cart.
- Metamucil Pak 4 in 1, with a note the nurse was to reorder when needed was only administered on 3/7, 3/11, 3/12 and 3/27. Other days Metamucil was marked not in cart, not available or unavailable.
- Pulmicort Inhaler, 1 puff twice daily for shortness of breath was documented as not in cart by staff beginning on 3/20. Tenant #3 missed 18 doses of Pulmicort.

4) Record review on 4/27/26 of a Resident Information form noted Tenant #8 was diagnosed with other anxiety disorders and unhappiness. Staff documented in the notes section of the April 2026 MAR he was out of Lorazepam 0.5 mg. on

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4/4. He was hospitalized from 4/5/26 and returned the evening of 4/13/26. Staff began notating on 4/14/26 the Lorazepam was not available at that time through 4/26/26.

On 4/23/26 at 7:40 AM Staff B and Staff E reported Tenant #8 told overnight staff he wanted her to put a pillow over his face to kill him. They believed this may be partially due to his lack of Lorazepam. A refill was called into the pharmacy but had not arrived. Staff B notified the Assistant Director of Health and Wellness (ADHW) of the need for a refill.

During a call with the pharmacy on 4/23/26 at 9:44 AM they explained someone at the Program attempted to refill the Lorazepam on 4/14/26 and 4/17/26. The pharmacy sent the Program a fax notifying them the physician would need to send a prior authorization to Medicare to pay for the medication. The tenant could also pay for the Lorazepam for a cost of $14.00.

Met with the ADHW on 4/23/26 at 11:20 AM who reported she had not contacted the pharmacy to follow up on Tenant #8's Lorazepam. Tenant #8 would be assessed for hospice later in the day and would likely receive Lorazepam through this program. She did not ask Tenant #8 about paying out of pocket for the medication.

5) On 4/28/26 at 7:50 AM during a medication pass Staff L noted there were two medication cards of Glipizide 10 mg. (one card for morning, one card for evening) in the cart for Tenant #9, but this medication was discontinued. Staff L reported she put sticky notes on these cards on 4/25/26: "not on MAR". Staff L was able to pull up a list of discontinued medication orders for Tenant #9. The Glipizide started on 4/2/26 and was

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discontinued on 4/16/26.

The morning Glipizide card was missing pills from the 4/17, 4/18, 4/19, 4/20, 4/21, 4/22, 4/23, 4/24 and 4/27 spots, which indicated the medication was administered to Tenant #9. The evening Glipizide card was tablets from the 4/16, 4/17, 4/18, 4/19, 4/20, 4/21, 4/23, 4/24 and 4/27 spots.

A review of Tenant #9's 4/28/26 Resident Information sheet, which included her medication orders, did not include the medication Glipizide.

The Program had a Medication Errors policy which noted a medication error was defined as any of the following:
- Wrong medication
- Wrong person
- Wrong dose
- Wrong route
- Wrong time
- Missed dose
- Not initiating an order

The individual identifying the medication error should immediately report it to a nurse or the Executive Director. The prescribing physician should immediately be notified of the error. Staff should document and follow instructions provided by the physician. They should monitor the tenant for signs and symptoms of serious adverse reactions. Staff should enter a narrative note on the tenant's status during every shift for 48 hours after a medication error occurred. The tenant's responsible party should be notified of the medication error. An internal occurrence form should be completed.

On 4/27/26 at 3:40 PM the ADHW stated she did not believe there were any med errors. She could

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A 274	Continued From page 53 not find any from the time the RN worked at the program (8/13/25 - 4/1/26). An exit meeting was held on 4/28/26 at 11:30 with the Executive Director and ADHW. At that time the ADHW stated she was aware there was a problem with the Program not documenting medication errors. She would work on educating staff and put a new system in place.	A 274		
A 276	481-69.25(1)q Tenant Document 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks will be part of the medication administration records (MARs); This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure staff accurately documented the completion of tasks on task sheets of 3 of 3 current tenants reviewed who were unable to advocate on their own behalf due to a cognitive impairment (Tenant #2, Tenant #3 and Tenant #6). Findings follow: A review of task sheets, care plans and Resident Assessments identified services tenants were	A 276	**A276 481-69.25(1)q Tenant Document** **Corrective Action:** DHW or ADHW will review resident service plans and assigned tasks and correct missing or inaccurate task assignments. **Prevention**: Care staff will be re-educated on timely, accurate documentation of completed, refused, or missed care. **Monitoring**: DHW or designee will audit 5 residents' task documentation weekly for 6 weeks, then monthly until 12/31/2026. **Correct Date**: 9/7/26	

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supposed to receive compared with what they did receive from 4/1/26 - 4/15/26. The tenants lived on the secured memory care unit and also received hourly safety checks. Examples of findings included the following:

1) The Resident Assessment for Tenant #2 dated 2/5/26 identified she scored less than 17 on the SLUMS or 4 or higher on the GDS (tools for measuring cognitive impairment) identifying she had dementia. The assessment noted she required assistance with bathing, dressing, oral care and toileting four times daily and as needed.
- 4/1/26: Staff documented providing dressing, oral care, toileting and safety checks at 4:51 AM. No other tasks were noted for the rest of the day.
- 4/2/26: The documentation of dressing, oral care, toileting, safety checks and socialization was done between 8:14 PM - 8:20 PM. Staff did not note they provided any cares earlier in the day.
- 4/15/26: Staff documented between 1:58 PM - 2:09 PM they assisted Tenant #2 with toileting three times, dining reminders twice and provided mobility assistance twice.
- There were no entries for bathing assistance.

2) Tenant #3 had a care plan dated 2/13/26 which noted she scored 5 on the Global Deterioration Scale indicating a moderately severe cognitive decline. She received hospice. Staff were to assist her with a bath one time weekly, dressing/undressing, oral care and toileting assistance every two hours.
- 4/1/26: Between 3:38 AM and 5:21 AM staff documented they providing toileting assistance six times. She received no other toileting assistance throughout the rest of the day.
- 4/2/26: Staff made three entries on the task sheet for providing toileting assistance to Tenant

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A 276	Continued From page 55 #3 at 4:55 AM. - 4/3/26: Staff documented Tenant #3 refused assistance with toileting (twice), oral care, hearing aids and dressing between 3:02 AM - 3:06 AM, an unusual time to assist individuals with these tasks. - 4/12/26: The only cares documented were toileting assistance (twice) at 5:13 AM. 3) Tenant #6 had a Resident Assessment dated 3/11/26. He had an enacted Power of Attorney and a diagnosis of unspecified dementia. Tenant #6 received services through various clinics at the VA and physical therapy. He required staff assistance with bathing, dressing, grooming and oral care. - 4/1/26: Staff documented assistance with oral care and eyewear at 4:53 AM. - 4/12/26, 4/14/26: no entries for any cares provided. - There were no entries for dressing or grooming on any of Tenant #6's task sheets. He received one bath on 4/15/26. During an interview with the Assistant Director of Health and Wellness on 4/27/26 at 3:40 PM she confirmed the Program failed to accurately document the completion of tasks for Tenants #2, #3 and #6.	A 276		
A 278	481-69.25(2) Tenant Documents 481-69.25(231C) Tenant documents. 69.25(2) The program records relating to a tenant shall be retained for a minimum of three years after termination of services. This REQUIREMENT is not met as evidenced	A 278	**A278 481-69.25(2)** **Tenant Documents** **Corrective Action**: ED, DHW or designee will review the discharged-resident record-retention process to ensure records are retained and retrievable for 3 years. **Prevention**: Staff responsible for records will be educated on retention and archiving requirements. **Monitoring**: ED or designee will audit discharged resident records weekly for 6 weeks, then monthly until 12/31/2026. **Correction Date**: 9/7/26	

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A 278	Continued From page 56 by: Based on interview and record review there was evidence the Program failed to retain information on 2 of 8 discharged tenants reviewed (Tenant C3 and Tenant C7). Findings follow: Requested records for Tenant C7 including nursing notes, task sheets and Medication Administration Records were not available for review. Requested records for Tenant C3 including nursing notes, task sheets and incident reports were not available for review. During an exit meeting with the Executive Director and Assistant Director of Health and Wellness on 4/28/26 at 11:30 AM they confirmed they were not able to produce the requested records.	A 278		
A 283	481-69.26(3)a Service Plans 481-69.26(231C) 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. The service plan shall be signed by all parties, including the tenant or tenant's legal representative. a. If a significant change does not exist, the program may, after nurse review, add minor discretionary changes to the service plan without a comprehensive evaluation and without obtaining signatures on the service plan.	A 283	**A283 481-69.26(3)a Service Plans** **Corrective Action:** DHW or ADHW will complete a 100% audit of current service plans for accuracy, updates after significant change, and required signatures. **Prevention**: DHW will be re-educated on service-plan timing, significant-change updates, and signature requirements. **Monitoring**: DHW or designee will audit 5 service plans weekly for 6 weeks, then monthly until 12/31/2026. **Correct Date**: 9/7/26	

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A 283	Continued From page 57 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update the service plan and/or ensure it was signed for 1 of 8 discharged tenants reviewed (Tenant C8) and 4 of 10 current tenants' whose service plans were reviewed (Tenant #2, Tenant #4, Tenant #5 and Tenant #6). Findings follow: 1) Record review on 4/21/26 of a progress note for Tenant C8 dated 2/5/26 revealed she had a noticeable decline over the past 14 days in her ability to perform the activities of daily living. She was no longer able to shower independently. She needed increased help in picking out clothing and putting it on correctly. She needed increased cuing for other tasks such as brushing her teeth and washing up. She had a noted decrease in appetite with lots of encouragement to take in fluids and food. Her son was aware. A change of condition was done and care plan updated. The Assistant Director of Health and Wellness reported during an interview on 4/27/26 at 3:40 PM she believed she updated Tenant C8's service plan but was unable to produce the document. 2) Record review of incident reports and progress notes for Tenant #6 on 4/15/26 revealed the following: - on 3/23/26 he was found laying on his floor at 12:33 AM. Staff asked if he was okay. He stated he hurt his back when he fell on the floor. Staff called the on-call nurse who directed him to contact the medics. Tenant #6 was transported to the hospital. - on 3/28/26 staff went into Tenant #6's apartment and found him on the floor. He reported he hit his	A 283		

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head. He was sent to the hospital.
- on 4/12/26, Tenant #6 returned from the emergency room following a fall. The nurse spoke with his daughter about getting a physical therapy and occupational therapy evaluation. She said she had one set up on 4/15/26.

A 30-day assessment and service plan were completed on 3/11/26. They noted he had no falls or history of falling.

The Program had a Falls policy which noted each tenant's service plan and fall risk evaluation would be reviewed and updated whenever a tenant had two or more falls within 30 days or a fall with injury requiring medical intervention.

The Assistant Director of Health and Wellness reported on 4/27/26 at 3:40 PM she updated Tenant #6's service plan but had not reviewed it yet with him or his daughter.

3) The Program was unable to produce a signed (or unsigned) service plan for Tenant #2.

4) The Program was unable to produce a signed (or unsigned) service plan for Tenant #4.

5) The Program was unable to produce a signed (or unsigned) service plan for Tenant #5.

During an exit meeting on 4/28/26 at 11:30 PM the Executive Director and Assistant Director of Health and Wellness confirmed the Program failed to update tenants' service plans when they experienced a change of condition. They also reported there were many service plans which were not signed by tenants or their representatives.

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A 318	Continued From page 59	A 318		
A 318	481-69.28(7) Food Service 481-69.28(231C) Food service. 69.28(7) All perishable or potentially hazardous food shall be cooked to recommended temperatures and held at safe temperatures of 41°F (5°C) or below, or 135°F (57°C) or above. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure food was held at safe temperatures, potentially affecting 14 of 14 tenants residing in the secured memory care unit. Findings follow: Observation on 4/14/26 at 4:35 PM revealed the warming cart containing the evening meal in the dining room. The cord was not plugged in. There were no staff or tenants in the room. The evening meal of beef stew over biscuits and onion rings was being served by Staff M on 4/14/26 at 5:17 PM. The temperature of the beef stew was 110 degrees. The temperature was verified by the Assistant Director of Health and Wellness (ADHW). She looked around and identified the issue as the cart being unplugged. The ADHW stated this has been an issue which was brought up with kitchen staff many times. The daughter of Tenant #11 was sitting in the dining room with her mother. When her mother received a plate of food she reported the biscuit and onion rings were cold to the touch. The daughter said they did not complain, but the food was often not warm.	A 318	**A 318 481-69.28(7)** **Food Service** **Corrective Action**: Dining staff will ensure the Memory Care dining cart's hot food is held at 135°F or above and cold food at 41°F or below before service. **Prevention**: Dining staff will be re-educated on temperature requirements and warming-equipment use. **Monitoring**: Food temperatures will be audited daily by the Director of Culinary Services or designee for 2 weeks, then weekly for 4 weeks, then monthly until 12/31/2026. **Correct Date**: 9/7/26	

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A 318	Continued From page 60 During an interview with the daughter of Tenant #6 on 4/14/26 at 8:55 AM she reported the food served in the secured memory care unit was often cold. Her father asked if she would buy him a slow cooker for his apartment so he could have warm food. An exit meeting was held on 4/28/26 at 11:30 AM and the ADHW again confirmed food was not served at an acceptable temperature on 4/14/26 during the evening meal and at other times.	A 318		
A 323	481-69.29(4) Staffing 481-69.29(231C) Staffing. In addition to the general staffing requirements in rule 481-67.9(231B,231C,231D), the following requirements apply to staffing in programs. 69.29(4) A dementia-specific assisted living program will have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff will be awake and on duty 24 hours a day on site and in the proximate area. A non-dementia-specific assisted living program will have one or more staff persons who monitor tenants as indicated in each tenant's service plan, 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure tenants received safety checks as required for 2 of 3 current tenants reviewed (Tenant #3 and Tenant #6) who lived on	A 323	**A 323 481-69.29(4) Staffing** **Corrective Action**: DHW or ADHW will review all Memory Care service plans and ensure required safety checks are assigned and completed as ordered. **Prevention**: Memory Care staff will be re-educated on visual checks, frequency, and real-time documentation. **Monitoring**: DHW or designee will audit 5 residents' safety checks weekly for 6 weeks, then monthly until 12/31/2026. **Correct Date**: 9/7/26	

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A 323	Continued From page 61 the secured memory care unit. Findings follow: 1) Tenant #3 had a care plan dated 2/13/26 which identified she would receive safety checks 12 times over the duration of each shift. Staff were to ensure she was wearing adequate footwear during each safety check. They were to go all the way into the room to complete each check. Tasks sheets dated 4/1/26 - 4/7/26 revealed the following: 4/1 - one safety check documented at 4:51 AM for the 6:00 PM - 6:00 AM shift, no documentation for the AM shift. 4/2 - one safety check documented at 8:15 PM for the 6:00 PM - 6:00 AM shift, no documentation for the AM shift. 4/3 - one safety check documented at 3:07 AM for the 6:00 PM - 6:00 AM shift, no documentation for the AM shift. 4/4 - one safety check documented at 8:07 PM for the 6:00 PM - 6:00 AM shift, no documentation for the AM shift. 4/5 - one safety check documented at 7:47 PM for the 6:00 PM - 6:00 AM shift, one safety check at 1:10 PM for the 6:00 AM - 6:00 PM shift. 4/6 - one safety check documented at 5:22 AM for the 6:00 PM - 6:00 AM shift, no documentation for the AM shift. 4/7 - one safety check documented at 10:00 PM for the 6:00 PM - 6:00 AM shift, no documentation for the AM shift. 2) Tenant #6 had a Care Plan dated 3/23/26. He was to receive 12 safety checks over the duration of each 12 hour shift. A review of task sheets dated 4/1/26 - 4/7/26 revealed the following: 4/1 - no safety checks. 4/2 - one safety check documented at 8:15 PM for the 6:00 PM - 6:00 AM shift, no documentation for the AM shift.	A 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0243	A. BUILDING: _____ B. WING _____	C 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 323	Continued From page 62 4/3 - one safety check documented at 3:07 AM for the 6:00 PM - 6:00 AM shift, no documentation for the AM shift. 4/4 - one safety check documented at 8:07 PM for the 6:00 PM - 6:00 AM shift, no documentation for the AM shift. 4/5 - one safety check documented at 7:47 PM for the 6:00 PM - 6:00 AM shift, no documentation for the AM shift. 4/6 - one safety check documented at 10:13 PM for the 6:00 PM - 6:00 AM shift, no documentation for the AM shift. 4/7 - one safety check documented at 10:14 PM for the 6:00 PM - 6:00 AM shift, no documentation for the AM shift. The Program had a Visual Checks Nurse Delegation Form which identified visual checks were meant to be completed as close to the scheduled time as possible. The key was for tenants to be viewed through an entire shift to ensure tenant safety. Falsification of documentation could lead to counseling and/or termination. A family member of Tenant C3 had a camera in his apartment and noted staff did not complete hourly checks. This was most evident when he suffered a fall on 1/1/26 which resulted in his death. He fell shortly after 2:38 AM. When she reviewed the camera footage she found no one checked on him until 7:00 AM. The family member did not ever check to see when he was last observed by staff prior to the fall around 2:38 AM. During an interview with the daughter of Tenant C4 on 4/14/26 at 3:05 PM she reported having a camera in her mother's apartment. Her mother lived on the secured memory care unit. The	A 323		

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A 323	Continued From page 63	A 323		

daughter reported there were multiple times no one checked on her mother from 10:00 PM - 6:00 AM. She would call the building to report this but no one would answer the phone. The daughter told the Executive Director she would start calling him if no one answered the phone at the Program.

The son of Tenant #20 reported there were 4 cameras in his mother's apartment. The staff generally did hourly checks on his mother during the week. Over the weekend staff did about 3-4 checks a night on his mom. His mother lived in the secured memory care unit.

The wife of Tenant C2 reported she would spend time in her husband's apartment on the secured memory care unit when interviewed on 4/8/26 at 8:30 AM. She stated hours would go by without anyone checking on her husband. There was no way for staff to know if her husband was alone as she could have left the apartment.

When interviewed on 4/23/26 at 10:05 AM Staff C stated there were times, especially at the beginning of 2026, when it was difficult for staff to complete hourly checks on tenants. There were tenants who were aggressive, easily agitated and at-risk for falls. When she was working by herself, she would focus her attention on keeping these tenants safe rather than risk waking other tenants up by completing the safety checks. Staff C said she notified the Registered Nurse and Executive Director of these issues and begged them to have two staff working at all times.

Staff J explained during an interview on 4/27/26 at 2:00 PM it was not possible to complete safety checks when working alone. At the beginning of the year, there were tenants who were up all

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A 323	Continued From page 64 night, falling and aggressive. There needed to be two individuals working but they were losing staff. The Assistant Director of Health and Wellness explained when interviewed on 4/27/26 at 3:40 PM staff were expected to complete checks every hour. Staff needed to know where tenants were at all times and document this. She stated Tenant C4 was into everything and Tenant #12 was tearing things apartment. Tenant #2 would stay up all night. When she first arrived at the Program she believed the memory care unit was not well managed. It was a major challenge. She confirmed staff were not documenting or completing checks as required on the service plans.	A 323		