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
	S0261	A. BUILDING: _____ B. WING _____	C 08/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD ESTATES AT HAWTHORNE CROS	601 HAWTHORNE CROSSING DR. SE BONDURANT, IA 50035

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Tenantswithout cognitive impairment: 26 Tenants with cognitive impairment: 21 Total census: 47 No regulatory insufficiencies were cited during the investigation of #131762-C, 131794-I and 132658-C. The following regulatory insufficiencies were cited during the investigation of #131808-I, #132368-C, #132407-C, #132636-C, #132640-C and #132751-C. ========== 231C.16A Medication setup - administration and storage of medications. 2. If medications are administered or stored by an assisted living program, or if the assisted living program provides for medication setup, all of the following shall apply: b. Medications, other than those self-administered by the tenant or provided through medication setup, shall be stored in locked storage that is not accessible to persons other than employees responsible for administration or storage of medications. Findings include:	A 000	See attached POC 10/30/26	

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A 000	Continued From page 1 Based on observations, interview and record review the Program failed to consistently ensure medications were only accessible to employees responsible for medication administration. This potentially pertained to 19 of 19 memory care unit tenants. Observations on 7/30/26 at 1:10 p.m. revealed the laundry/medication room and medication cabinet unlocked. Further observations revealed medication keys laid on the counter and medication cabinet unlocked. When asked, Staff B admitted she failed to ensure the medication keys were not accessible to anyone who entered the unlocked laundry room/medication storage area. Further observation revealed a staff member handed a set of keys, including medication keys, to Staff B upon entering the laundry/medication storage area. Staff B confirmed these keys belonged to the medication administration set. Staff B stated employees frequently requested her keys because they contained a master key, which was otherwise unavailable to them When interviewed on 8/11/26 at 4:00 p.m., the Director confirmed medication keys were accessible to unauthorized staff. The keys were left unattended on the laundry room counter where narcotic medications were stored. Furthermore, staff utilized keys assigned to medication administration personnel.	A 000		
A 122	481-67.3(2) Tenant Rights 481-67.3(231B,231C,231D) Tenant rights. All tenants have the following rights:	A 122		

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A 122	Continued From page 2 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 ensure the provision of adequate and appropriate care, treatment, and services for 1 of 1 tenant (Tenant #1) hospitalized during the on site visit and 2 of 2 tenants (Tenants #7 and #12) whose medication errors were reviewed. Findings follow: 1. When interviewed on 7/30/26 at 9:40 a.m., a family member reported concerns regarding Tenant #1's unmet care needs. The family noted Tenant #1, who had a diagnosis of multiple sclerosis (MS), required staff assistance for all transfers. While historically independent with activities of daily living once in her wheelchair, the family observed a significant functional decline over the preceding three weeks, including speech difficulties and increased tremors affecting nutritional intake. The family member further reported Tenant #1 was left on the toilet for up to 45 minutes; citing these concerns, they installed a surveillance camera in the apartment. Tenant #1 was hospitalized on 7/28/26 and remained admitted as of 7/30/26. A review of screenshots of camera footage on 8/3/26 revealed Tenant #1 remained in bed from approximately 6:15 p.m. on 7/26/26 until 10:34 a.m. on 7/27/26. Record review on 8/11/26 revealed Tenant #1's 7/13/26 service plan identified staff were directed to provide total assistance with transfers and	A 122		

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positional changes, and to remind the tenant to call for assistance with transfers. The plan also mandated repositioning for chronic and acute pain management and required staff to encourage both fluid and food consumption throughout the day. Regarding urinary health, the plan directed staff to monitor for symptoms of urinary tract infections (UTIs), report changes to the nurse, and initiate fluid intake upon symptom onset. The service plan noted would care was completed by PACE as prescribed.

Record review on 8/12/26 of Tenant #1's Progress Notes revealed the following:

On 7/13/26 the Progam completed a change of condition and updated her service plan due to three falls within 30 days. Tenant #1 had increased need of assistance with transfers in/out of bed and on and off of toilet due to legs giving out. PACE updated. Therapy requested due to increased falls and need for transfer assistance

On 7/27/26 at 3:00 p.m. the Health Care Coordinator documented the PACE nurse completed wound care and labs. The nurse reported the tenant's wounder significantly worsened with new wounds forming to the heel and lower calf of the right foot/leg. Tenant #1 appeared signficantly weaker. The tenant was ordered ensure and Juven drinks for wound health. The PCP wanted lab results before sending resident to the ED for slurred speech and weakness.

On 7/27/26 at 9:52 p.m. the HCC documented the PACE nurse reported an on-call nurse was out to see resident after receiving a call from the community the tenant was having increased difficulty standing. On-call PACE nurse attempted

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to give IV fluids but was unable to do so due to blowing a vein. The nurse would follow up for an additional attempt to give fluids.

On 7/28/26 at 9:28 a.m. the HCC documented a nurse from the PACE program reported they were sending Tenant #1 to the ER after receiving lab results. Resident was very weak and unable to bear weight through legs without asistance. The tenant had little control of arms and upper body. Staff assisting resident to keep sitting position on toilet. The nurse assisted resident from toilet to wheelchair. Resident was unable to get words to form and speech was completely garbled. EMS arrived. PACE nurse provided updates on resident lab results and updated EMS. WBC (white blood cell) 14. Labs indicated resident was dehydrated with infection likely from wound. Urine obtained, negative.

Record review on 8/12/26 revealed Tenant #1's pendant response log included multiple occurrences of significantly delayed staff response times. Examples of these response durations included, but were not limited to:
7/27/26: 196 minutes and 51 seconds
7/4/26: 152 minutes and 40 seconds
7/13/26: 91 minutes and 58 seconds
7/6/26: 67 minutes and 44 seconds
7/5/26: 53 minutes and 7 seconds
7/16/26: 51 minutes and 6 seconds

Tenant #1's medical history included multiple sclerosis, recurrent major depressive disorder, unspecified peripheral vascular disease, a non-pressure chronic ulcer, and hyperlipidemia. Tenant #1's hospital discharge summary, dated 7/28/26, noted the hospital admitted Tenant #1 for sepsis, suspected secondary to right lower extremity cellulitis, and hypernatremia (high

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concentration of sodium in the blood meaning the body has too little water for the amount of sodium).

During an interview on 8/5/26 at 1:08 p.m., Staff F stated she did not consistently answer pendants when busy. She noted while the program directs staff to answer as soon as possible, she may choose to ignore a pendant depending on which tenant activated it.

When interviewed on 8/10/26 at 12:30 p.m., Staff C stated staff were instructed to respond to tenant pendants as soon as possible, noting a response delay exceeding two hours could result in disciplinary action.

During an interview on 8/11/26 at 4:00 p.m., the nurse confirmed the program lacked documentation to verify the delivery of additional services, as outlined in Tenant #1's 7/13/26 service plan, to address the tenant's increased care needs. They also said staff had been directed to respond to tenant emergency pendants "as soon as possible."

2. During an interview on 8/3/26 at 9:00 a.m., an interviewee reported Program staff failed to remove Tenant #7's used Rivastigmine transdermal patch prior to applying a new patch. An aide from an outside provider originally brought this issue to the attention of the Program Nurse after observing multiple transdermal patches on Tenant #7's back. The outside provider identified a patch that had belonged to a deceased individual on Tenant #7.

Record review revealed Tenant #7's medication administration record for June and July 2026

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included Rivastigmine Transdermal Patch 24 Hour 9.5mg/24hr, one patch 24 hours onto the skin one time per day every day at 8:00 a.m. The MAR included an additional note, "Remove old patch first!!!"

When interviewed on 8/5/26 at 1:53 p.m. Staff B confirmed she found two patches on Tenant #7 and notified the Program's nurse.

On 8/10/26 Staff D confirmed she observed four to five patches on Tenant #7's back and reported this to the Program's nurse.

Mayo Clinic prescribing precautions for transdermal Rivastigmine explicitly directed previously applied patches must be removed before applying a new patch to avoid serious side effects, such as toxicity or overdose.

Record review on 8/12/26 revealed the Program's written direction for application of transdermal patches no date. Per the document step three stated, "remove old patch form the resident." "Report any unusual observations to the supervisor."

Continued record review failed to produce documentation from the Program nurse regarding notification of multiple patches found on Tenant #7.

During an interview on 8/4/26 at 3:21 p.m. the Program Director and Nurse said the incident appeared to be an isolated event and the Program nurse provided relevant staff verbal directions for proper application of transdermal patches. They admitted they failed to identify the staff responsbile for improper application of Tenant #7's Rivastigmine transdermal patch

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A 122	Continued From page 7 and/or provide additional training regarding transdermal patch application. 3. Record review on 8/24/26 revealed a medication error/incident report for Tenant #12 dated 7/20/26. The report documented Staff H administered the roommate's medications to Tenant #12. The improperly administered medications included: Quetiapine 75 mg, Melatonin 10 mg, Trazodone 150 mg, Tamsulosin 0.5 mg, Midodrine 2.5 mg, and Docusate 50 mg. At 7:05 p.m., the Resident Assistant (RA) noted Tenant #12 exhibited drowsiness and complained of dizziness. Program staff notified the tenant's Nurse Practitioner, who recommended evaluation at the emergency department. Following evaluation by the emergency department Tenant #12 returned to the Program with no new orders. Record review on 8/25/26 revealed a counseling documentation form noting a date of occurrence 7/20/26 and signed 8/25/26 with a notation Staff H had been on leave from 7/31/26 -8/20/26. When interviewed on 8/24/26 at 4:00 p.m. the Vice President of Clinical Operations said the Program Nurse provided Staff H verbal coaching at the time of the medication error. On 8/25/26 during the exit the Director confirmed no documentation of disciplinary action prior to 8/25/26 (the date of exit and after being questioned by the surveyor).	A 122		
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:	A 152		

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A 152	Continued From page 8 e. When medications are administered traditionally by the program: (3) Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or PA. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, staff failed to administer medications in accordance with physician orders. This pertained to 1 of 3 tenants (Tenant #14) observed during medication administration in the memory care unit and 1 of 1 tenant (Tenant #12) who required emergency department evaluation following a medication error. Findings follow: 1. Observations on 8/24/26 at 2:15 p.m. revealed Tenant #14's Sucralfate tablet sat unattended on her kitchen counter. When questioned, Staff G failed to verbalize the correct procedure regarding the unattended medication. Staff F (identified as a Lead Resident Assistant responsible for training) in the room to remove trash exhibited reluctance to assist or guide Staff G. Staff G admitted she administered noon medications but failed to ensure Tenant #14 swallowed/ingested the dose as ordered. When asked for the next appropriate step, Staff G appeared unsure. After prompted, Staff G and Staff F acknowledged failure to ensure Tenant #14 ingested/swallowed her Sucralfate would be considered a medication error. Staff G notified the Program nurse.	A 152		

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A 152	Continued From page 9 Review of Tenant #14's Physician's Orders on 8/25/26 revealed an order for Sucralfate 1 gram: 1 tablet four times daily, effective 7/12/26. When interviewed on 8/24/26 at 2:30 p.m., the nurse confirmed the medication error. Record review on 8/24/26 at 4:00 p.m. revealed an employee counseling form for Staff G dated 8/24/26. The form documented Staff G's failure to observe Tenant #14 ingest her medication, which resulted in a missed dose of Sucralfate. 2. Record review on 8/24/26 revealed a medication error/incident report for Tenant #12 dated 7/20/26. The report documented Staff H administered the roommate's medications to Tenant #12. The improperly administered medications included: Quetiapine 75 mg, Melatonin 10 mg, Trazodone 150 mg, Tamsulosin 0.5 mg, Midodrine 2.5 mg, and Docusate 50 mg. At 7:05 p.m., the Resident Assistant (RA) noted Tenant #12 exhibited drowsiness and complained of dizziness. Program staff notified the tenant's Nurse Practitioner, who recommended evaluation at the emergency department. Following evaluation by the emergency department Tenant #12 returned to the Program with no new orders. Record review on 8/25/26 revealed a counseling documentation form noting a date of occurrence 7/20/26 and signed 8/25/26 with a notation Staff H had been on leave from 7/31/26 -8/20/26. During an interview on 8/24/26 at 4:00 p.m. the Vice President of Clinical Operations said the Program Nurse provided Staff H verbal coaching at the time of the medication error. On 8/25/26 during the exit the Director confirmed no	A 152		

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A 152	Continued From page 10 documentation of disciplinary action prior to 8/25/26 (the date of exit and after being questioned by the surveyor).	A 152		
A 191	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 observations, interviews, and record review, the Program failed to consistently provide an adequate number of appropriately trained staff to meet tenants' needs. This pertained to 2 of tenants 2 (Tenants #1 and #7) reviewed for staff response to personal emergency response system. Findings follow: 1. When interviewed on 7/30/26 at 9:40 a.m. family expressed concerns regarding Tenant #1's increased care needs and the Program's failure to address the needs. Tenant #1 went to the hospital on 7/28/26 and remained there on 7/30/26 during the interview. The family explained Tenant #1 had multiple sclerosis (MS) used a wheelchair and depended on staff to assist her to transfer from bed to her wheelchair. Historically Tenant #1 had been independent with most activities of daily living once transferred to her wheelchair. The past three weeks family noted Tenant #1 had experienced significant decline which made it difficult for Tenant #1 to speak. Increased tremors made it difficult for Tenant #1 to eat and drink. Tenant #1 reported being left on the toilet for up to 45 minutes. The family	A 191		

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reported they installed a camera in Tenant #1's room due to concerns regarding the care the Program provided. Review of camera footage revealed Tenant #1 laid in bed on 7/26/26 from approximately 6:15 p.m. till 7/27/26 at 10:34 a.m.

Record review revealed Tenant #1's service plan, updated 7/13/26, revealed Tenant #1 had a history of falls with injuries. The service plan noted they should call for assistance if sliding out of chair, to ask for assistance picking up items from the floor, for assistance with transfers. The service plan noted they were encouraged to ask for assistance rather than bending down in shower to grab things. The tenant had been provided a grabber for picking items up from the floor. The service plan noted Tenant #1 may require hands on assistance from staff for mobility and ambulation and required total assistance with transfers and/or changes in position, as well as extensive assistance with toileting tasks.

Record review on 8/12/26 revealed Tenant #1's pendant response record. Examples included but were not limited to the following staff response times for Tenant #1's pendant:
- 7/27/26 196 minutes and 51 seconds
- 7/4/26 152 minutes and 40 seconds
- 7/13/26 91 minutes and 58 seconds
- 7/6/26 67 minutes and 44 seconds
- 7/5/26 53 minutes and 7 seconds
- 7/16/26 51 minutes and 6 seconds

2. Record review revealed Tenant #7's service plan, dated 4/9/26, noted he required reminders to call for assistance due to falls. Tenant #7 was independent with transferring and ambulated

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independently with a walker and gait belt. Tenant #7 required standby assistance for toileting tasks.

Additional record review on 8/12/26 revealed Tenant #7's pendant response record. Examples included but are not limited to the following staff response times for Tenant #7's pendant:
- 8/5/26 108 mminutes and 51 seconds
- 8/3/26 43 minutes and 48 seconds
- 8/10/26 36 minutes and 59 seconds
- 8/8/26 31 minutes and 59 seconds

3. Interviews completed during the onsite visit revealed the following:
- Staff F reported staff were so busy, if she saw certain tenant names on the pendant system she ignored them because she did not have time to respond to them.

-Staff D reported the usual staffing included three staff, one in assisted living and two in memory care. The staff assigned to assisted living have responsibility to respond to personal emergency response pendants as soon as possible within 10 minutes. Monitor door alarms including the front door and administer medications.

When interviewed on 8/10/25 at 2:20 p.m. Staff C reported one staff usually covered the assisted living and the second staff in memory care assisted/floated, if needed. The Program scheduled three staff in the building to care for the 47 tenants. She also mentioned staff assigned to assisted living had responsibility to check the door alarms including the front door.

When interviewed on 8/5/26, Staff A and Staff B reported the Program scheduled only three staff in the building, two in memory care and one in assisted living for first and second shift to care for

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 191	Continued From page 13 the 47 tenants. During an interview on 8/11/26 at 4:00 p.m. the Director and Nurse explained the Program determined four staff sufficient to meet the needs of the 47 tenants, which included 19 tenants in memory care. They admitted the Program typically had three staff working, one assigned to assisted living part of the building.	A 191		
A 199	481-67.9(4)e 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: e. The program's nurse(s) will provide direct or indirect supervision of all direct care staff as necessary in the professional judgment of the program's nurse(s) and in accordance with the needs of the tenants and staff. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the Program's nurse failed to consistently provide adequate supervision to ensure staff were competent to meet tenant needs. This pertained to 3 of 6 tenants who resided in the assisted living part of the building (Tenants #1, #7 and #12). Findings follow: 1. During an interview on 8/3/26 at 9:00 a.m., an interviewee reported Program staff failed to remove Tenant #7's used Rivastigmine	A 199		

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A 199	Continued From page 14	A 199		

transdermal patch prior to applying a new patch. An aide from an outside provider originally brought this issue to the attention of the Program Nurse after observing multiple transdermal patches on Tenant #7's back. The outside provider identified a patch that had belonged to a deceased individual on Tenant #7.

Record review revealed Tenant #7's medication administration record for June and July 2026 included Rivastigmine Transdermal Patch 24 Hour 9.5mg/24hr, one patch 24 hours onto the skin one time per day every day at 8:00 a.m. The MAR included an additional note, "Remove old patch first!!!"

When interviewed on 8/5/26 at 1:53 p.m. Staff B confirmed she found two patches on Tenant #7 and notified the Program's nurse.

On 8/10/26 Staff D confirmed she observed four to five patches on Tenant #7's back and reported this to the Program's nurse.

Mayo Clinic prescribing precautions for transdermal Rivastigmine explicitly directed previously applied patches must be removed before applying a new patch to avoid serious side effects, such as toxicity or overdose.

Record review on 8/12/26 revealed the Program's written direction for application of transdermal patches no date. Per the document step three stated, "remove old patch form the resident." "Report any unusual observations to the supervisor."

Continued record review failed to produce documentation from the Program nurse regarding notification of multiple patches found on Tenant

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A 199	Continued From page 15 #7. During an interview on 8/4/26 at 3:21 p.m. the Program Director and Nurse said the incident appeared to be an isolated event and the Program nurse provided relevant staff verbal directions for proper application of transdermal patches. They admitted they failed to identify the staff responsbile for improper application of Tenant #7's Rivastigmine transdermal patch and/or provide additional training regarding transdermal patch application. 2. On 7/30/26 at 9:40 a.m., a family member reported concerns regarding Tenant #1's unmet care needs. The family noted Tenant #1, who had a diagnosis of multiple sclerosis (MS), required staff assistance for all transfers. While historically independent with activities of daily living once in her wheelchair, the family observed a significant functional decline over the preceding three weeks, including speech difficulties and increased tremors affecting nutritional intake. The family member further reportedTenant #1 was left on the toilet for up to 45 minutes; citing these concerns, they installed a surveillance camera in the apartment. Tenant #1 was hospitalized on 7/28/26 and remained admitted as of 7/30/26. A review on 8/3/26 of screenshots of camera footage provided by the interviewee revealed Tenant #1 remained in bed from approximately 6:15 p.m. on 7/26/26 until 10:34 a.m. on 7/27/26. Record review on 8/11/26 of the tenant's 7/13/26 service plan identified staff were directed to provide total assistance with transfers and positional changes, and to remind the tenant to call for assistance with transfers. The plan also mandated repositioning for chronic and acute	A 199		

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pain management and required staff to encourage both fluid and food consumption throughout the day. Regarding urinary health, the plan directed staff to monitor for symptoms of urinary tract infections (UTIs), report changes to the nurse, and initiate fluid intake upon symptom onset.

Record review on 8/12/26 of Tenant #1's pendant response log revealed multiple instances of significantly delayed staff response times. Examples of these response durations included but were not limited to:
7/27/26: 196 minutes and 51 seconds
7/4/26: 152 minutes and 40 seconds
7/13/26: 91 minutes and 58 seconds
7/6/26: 67 minutes and 44 seconds
7/5/26: 53 minutes and 7 seconds
7/16/26: 51 minutes and 6 seconds

Tenant #1's medical history included multiple sclerosis, recurrent major depressive disorder, unspecified peripheral vascular disease, a non-pressure chronic ulcer, and hyperlipidemia. Tenant #1's hospital discharge summary dated 7/28/26, noted the hospital admitted Tenant #1 for sepsis, suspected secondary to right lower extremity cellulitis, and hypernatremia (high concentration of sodium in the blood meaning the body has too little water for the amount of sodium).

Record review on 8/12/26 of Tenant #1's Progress Notes revealed on 7/13/26 the Progam completed a change of condition and updated her service plan due to three falls within 30 days. Tenant #1 had increased need of assistance with transfers in/out of bed and on and off of toilet due to legs giving out. PACE updated. Therapy requested due to increased falls and need for

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A 199	Continued From page 17 transfer assistance During an interview on 8/5/26 at 1:08 p.m., Staff F stated she does not consistently answer pendants when busy. She noted while the program directs staff to answer as soon as possible, she may choose to ignore a pendant depending on which tenant activated it. On 8/10/26 at 12:30 p.m., Staff C stated staff were instructed to respond to tenant pendants as soon as possible, noting a response delay exceeding two hours could result in disciplinary action. During an interview on 8/11/26 at 4:00 p.m., the nurse confirmed the program lacked documentation to verify the delivery of additional services, as outlined in Tenant #1's 7/13/26 service plan, to address the tenant's increased care needs. She also said staff had been directed to respond to tenant emergency pendants "as soon as possible." 3. Record review on 8/24/26 revealed a medication error/incident report for Tenant #12 dated 7/20/26. The report documented Staff H administered the roommate's medications to Tenant #12. The improperly administered medications included: Quetiapine 75 mg, Melatonin 10 mg, Trazodone 150 mg, Tamsulosin 0.5 mg, Midodrine 2.5 mg, and Docusate 50 mg. At 7:05 p.m., the Resident Assistant (RA) noted Tenant #12 exhibited drowsiness and complained of dizziness. Program staff notified the tenant's Nurse Practitioner, who recommended evaluation at the emergency department. Following evaluation by the emergency department Tenant #12 returned to the Program with no new orders.	A 199		

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A 199	Continued From page 18 Record review on 8/25/26 revealed a counseling documentation form date of occurence 7/20/26 signed 8/25/26 with a notation Staff H had been on leave from 7/31/26 -8/20/26. An interview on 8/24/26 at 4:00 p.m. the Vice President of Clinical Operations said the Program Nurse provided Staff H verbal coaching at the time of the medication error. On 8/25/26 during the exit the administrative team confirmed no documentation of disciliplinary action prior to 8/25/26 (the date of exit and after being questioned by the surveyor). She also confirmed the Program lacked documentation of supervision audits to ensure staff were competent to meet tenant needs.	A 199		
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 document nurse ' s notes by exception for 1 out of 1 tenant (Tenant #7) who	A 268		

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A 268	Continued From page 19	A 268		

had transdermal patches applied incorrectly. Finding follows:

During an interview on 8/3/26 at 9:00 a.m., an interviewee reported Program staff failed to remove Tenant #7's used Rivastigmine transdermal patch prior to applying a new patch. An aide from an outside provider originally brought this issue to the attention of the Program Nurse after observing multiple transdermal patches on Tenant #7's back. The outside provider identified a patch that had belonged to a deceased individual on Tenant #7.

The interviewee noted Tenant #7 had experienced increased falls, which could have been attributed to medication overdose resulting from the application of multiple patches. Mayo Clinic prescribing precautions for transdermal Rivastigmine explicitly state previously applied patches must be removed before applying a new patch to avoid serious side effects, such as toxicity or overdose.

When interviewed on 8/5/26 at 1:53 p.m. Staff B confirmed she found two patches on Tenant #7 and notified the Program's nurse.

When interviewed on 8/10/26 Staff D confirmed she observed four to five patches on Tenant #7's back and reported this to the Program's nurse.

Further review of Tenant #7's Progress/Nurses Notes on 8/3/26, revealed the Program Nurse failed to document the reported concern regarding the multiple patches found on the tenant's back.

During an interview on 8/4/26 at 3:21 p.m. the Program Director and Nurse said the incident

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A 268	Continued From page 20 appeared to be an isolated event and the Program nurse provided relevant staff verbal directions for proper application of transdermal patches. They admitted they failed to identify the staff responsible for improper application of Tenant #7's Rivastigmine transdermal patch and note the concern in Tenant #7 ' s Progress/Nurses notes.	A 268		
A 366	481-69.32(2) Life Safety 481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements. 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure an operating alarm system connected to all exit doors. This pertained to 2 of 2 tenants (Tenant #4 and #5) who eloped through an unalarmed door and potentially all tenants who resided in the memory care unit. Finding follows: Observations on 7/30/26 revealed Staff H took out the trash using the south memory care door. He propped open the alarmed gate while placing items in the dumpster. He could not visualize the open gate while he loaded the dumpster. During an interview on 8/5/26 at 12:58 p.m. the Director confirmed two tenants eloped when staff propped the south memory care unit door open to	A 366		

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take the trash out. She confirmed a former staff admitted to propping the door open.

Record review on 8/12/26 revealed the Program's internal investigation dated 3/21/26. The investigation report noted former staff propped open the alarmed door/gate and two tenants walked outside unsupervised.

Staff statements taken during the investigation detailed two separate former staff members observed Tenant #4 and Tenant #5 outside dining room of the assisted living part of the building. Tenant #4 and Tenant #5 approached the dining room door and attempted to re-enter the building. The dining room door was located 50 - 75 yards from the door the tenant's used to exit.

Observations on 8/11/26 revealed a farm field within 50 yards South of the unalarmed door. The Program sat .2 miles from Iowa Highway 330 which had a 55 mile per hour speed limit.

Record review on 8/12/26 revealed the Program's Dementia Specific Program policy, dated 6/15/25, mandated each exit door possess an operating alarm system.

On 8/25/26 review of Underground Weather historical data revealed a measured temperature of 86 degrees Fahrenheit at 1:15 p.m. on 3/21/26.

Record review on 8/12/26 revealed a Global Deterioration Scale score of four (moderate cognitive decline) for both Tenant #4 and Tenant #5. Tenant #4's service plan dated 11/25/25 noted history of occassional disorientation to person, place or situation even in familar surroundings and require supervision, oversight for safety, difficulty remembering/using information and

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A 366	Continued From page 22 required some directions from others. Both tenants resided in the memory care unit. Record review on 8/12/26 revealed a counseling documentation final warning form with a recorded occurrence date of 3/21/26. In this document, the Program noted Staff E propped open the secured/alarmed door. When interviewed on 8/11/26 the Director confirmed the Program failed to ensure an operating alarm system when staff propped open the door in the memory care unit to take trash to the dumpster.	A 366		
A 385	481-69.35(1) Activities 481-69.34(231C) Activities. The program shall have a policy related to activities, including the following: 69.34(1) The program will provide appropriate activities for each tenant reflecting individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skills by providing opportunities for a variety of types and levels of involvement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the program failed to consistently provide opportunities for appropriate activities for 1 of 1 tenant who expressed a desire to participate in Bingo and potentially pertained to 18 of 18 remaining or additional tenants who resided in the memory care unit.	A 385		

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A 385	Continued From page 23 Observations on 7/30/26 at revealed several tenants seated in the common/television activity area with the television playing. Observations on 8/10/26 at 1:15 p.m. revealed tenants played Bingo in the main dining room of the assisted living section of the building. Concurrent observations in the memory care unit revealed four tenants seated in the common/television activity area with the television playing. At 1:37 p.m., two tenants walked up and down the hallway. At 1:55 p.m., several female tenants remained seated in the area with the television playing. One tenant inquired regarding the time meals would arrive. Observations on 8/24/26 between 12:50 p.m. and 2:15 p.m. revealed six tenants seated in the common/television area while the television played. One additional tenant joined the group, sat near the television, and craned her neck to view the screen. One tenant consumed a snack bag of Cheetos. Another tenant reviewed a circle-a-word puzzle book. Two tenants sat in the dining room; one slept with her head falling backwards, and the other sat at a table. At 1:35 p.m., no facility staff could be located within the unit when an outside provider requested egress from the locked memory care unit. At 1:41 p.m., Staff F exited the laundry/medication storage room, while another staff member remained inside the room. At 1:42 p.m., Staff F left the memory care unit, while Staff G remained inside the laundry/medication room. Tenant #13 wandered and rattled the secured door leading to the assisted living side. An outside provider staff member attempted to encourage Tenant #13 to sit near the television, which the tenant refused before she resumed hallway wandering. At 1:47 p.m., staff provided a snack bar to Tenant #13.	A 385		

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Tenant #13 continued to wander the hallways while holding the snack bar. At 1:49 p.m., Tenant #13 rattled the memory care door. At 1:49 p.m., Staff F returned to the memory care unit and complained aloud to other staff regarding mandated hours due to a staff call-off. At 1:55 p.m., Tenant #13 continued to wander the hallway with the snack bar. An unidentified tenant stated, "Are we having Bingo? Oh no, that says it's the 17th. Is today the 17th?" The tenant referred to the daily calendar posted on the wall in the common/television area of the memory care unit. When asked if she would like to play Bingo, the tenant responded, "sure."

A review of the posted daily calendar revealed it reflected activities for the prior week of August 17th through August 23rd. One tenant repeatedly exhibited exit-seeking behavior at the locked door, knocking on and rattling it in an attempt to leave the area. Staff F walked from room to room but failed to interact with the tenants. A tenant approached and stated a need to make a telephone call. The surveyor reported the tenant's request to staff. Staff F inquired to this surveyor, "Who does she need to call?" while walking toward the tenant's apartment. At 1:35 p.m., three tenants remained in the area with the television playing.

Further observations revealed an activity calendar on the bulletin board for the month of August.

Record review on 8/25/26 revealed Tenant #13's service plan dated 5/9/26 directed staff Tenant #13 enjoyed planned and preferred activities, required frequent verbal reminders and may need physical assistance.

Interviews during the onsite visit revealed the

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A 385	Continued From page 25 following: On 8/5/26 at 1:53 p.m. Staff B said the Program failed to offer tenants in the memory care unit activities. She confirmed the activities person spent most of her time in the assisted living part of the building. On 8/10/26 at 12:30 p.m Staff C said tenants in the memory care unit are not often offered activities. She said the activity staff spent most time with the assisted living tenants even though her office was located in memory care. She also mentioned the Program lacked games, puzzles and other activity supplies. Record review on 8/24/26 revealed the Program's Emergency Pendant System Alarm dated 5/15/24. Per the policy staff would do visual checks and remind tenants of the activities of the day. On 8/11/26 4:00 p.m. the Director and Nurse confirmed the Program provided activities for the assisted living area of the building. They said memory care tenants could participate although tenants in memory care had not been offered activities during observations. They also confirmed tenants in memory care should have opportunities to participate in activities.	A 385		
A 391	481-69.35(1)b Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. b. The buildings and grounds will be well-maintained, clean, safe and sanitary.	A 391		

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COURTYARD ESTATES AT HAWTHORNE CROS	601 HAWTHORNE CROSSING DR. SE BONDURANT, IA 50035

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 391	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observations and interviews the Program failed to ensure a clean, sanitary, and well-maintained environment. This potentially affected all tenants residing at the Program but specifically 19 of 19 in memory care. Findings follow: During an interview on 8/5/26 at 11:10 a.m., an outside provider described the apartment of Tenant #6 as "filthy". The provider reported on 6/23/26 they observed feces on the tenant's wall and a large stain resembling feces on the carpet. The outside provider also observed the closet door off the hinges, no washcloths and towels to bath Tenant #6 and no toilet paper in the bathroom. Program staff claimed the tenant's family was responsible for cleaning the apartment. The outside provider requested his employer not assign him to provide future care to the tenant due to the poor environmental conditions. When interviewed on 8/5/26 at 1:53 p.m. Staff B said the Program had recently cleaned Tenant #6's apartment because they thought the family would be coming to move out his things since he had been hospitalized, but in the past she observed it be unkept. She added the Program had one housekeeper for the entire building. She had been assigned as the housekeeper and it had been difficult to keep up with the cleaning of the entire building. Observations of the memory care unit revealed a strong, persistent odor of urine on the following dates and times:	A 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0261	A. BUILDING: _____ B. WING _____	C 08/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 391	Continued From page 27 - 7/30/26 at 12:50 p.m. - 8/5/26 at 12:00 p.m. and 12:45 p.m. - 8/10/26 from 1:35 p.m. to 1:50 p.m. - 8/24/26 from 1:10 p.m. to 2:15 p.m. During interviews conducted on 8/5/26 (1:31 p.m. and 1:53 p.m.) and 8/10/26 (12:30 p.m. and 12:41 p.m.), Staff A, B, C, and D confirmed the memory care unit frequently smelled of urine. Staff reported the following: - The Program failed to address the ongoing odor issues. - Urine-soaked briefs frequently remained in tenant trash cans for the duration of a shift. - Tenant #12 regularly refused to allow staff to assist him to change his incontinence brief Observations on 7/30/26 between 12:50 p.m. and 1:15 p.m. confirmed used adult incontinence products were present in tenant trash cans. On 8/11/26 at 4:00 p.m. the Director and Nurse acknowledged the strong smell of urine but offered no solutions. They confirmed the Program needed to ensure a better environment for the tenants in memory care.	A 391		

COURTYARD ESTATES AT HAWTHORNE CROSSING

PLAN OF CORRECTION

Complaint Visit July-Aug 2026				
Rule Reference	**SUMMARY OF DEFICIENTCIES/Concern**	**PLAN OF CORRECTION**	**Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.**	**COMPLETION DATE**
231C.16A	**231c.16A Medication setup -** administration and storage of medications.	Instant Inservice Education regarding possession of medication keys was completed for all staff by 10/30/26.	HCC/Director/Designee to audit securing of medications and key access weekly for 4 weeks or until compliance is maintained. Director/Nurse/Designee shall audit new staff to ensure education is received on mediation administration and storage as applicable weekly x 4 weeks, monthly x 3 weeks or as needed.	Implementation Date: 8/6/26 Completion Date: **9/22/26** Responsible Party: **Director/Designee** Implementation Date: 9/1/26 Completion Date: **Ongoing** Responsible Party: **Director/Designee** Implementation Date: 10/9/26 Completion Date: **10/30/26** Responsible Party: **Director/Designee**

A 122-**Part 1**	**67.3(2) Tenant Rights**. A 67.3(2) To receive care, treatment and services that are adequate and appropriate. Based on interview and record review, the program failed to ensure the provision of adequate and appropriate care, treatment, and services 1 of 1 tenant (Tenant #1) hospitalized during the on site visit and 2 of 2 tenants (Tenants #7 and #12) whose medication errors were reviewed.	T1 discharged from the community on 7/29/26. All current residents shall have a review of skin health by 10/31/26. All current staff was educated on Door Alarm Response, Pendant Response, Exception Log by 9/28/26. All staff shall receive training on resident rights, by 10/31/2026.	Nurse/Director/Designee shall Audit 4 times weekly for 4 weeks, monthly and as needed of Pendant/Door Alarm Response and Exception Log. Nurse/Director/Designee shall audit tenant rights and adequate services 4 times weekly for 4 weeks, monthly or until compliance is maintained.	Implementation Date: 8/10/26 Completion Date: 9/28/26 Responsible Party: **Director/Designee** Implementation Date:9/19/26 Completion Date: **Ongoing** Responsible Party: **Director**
A 122-**Part 2**	**67.3(2) Tenant Rights**. 2 of 2 tenants (Tenants #7 and #12) whose medication errors were reviewed: e. When medications are administered traditionally by the program:(3) Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or PA.	T7 was assessed by nurse 6/19/2026. Current medication delegated staff will receive education regarding medication patch application and removal by 10/31/2026. T12 was evaluated at the emergency department following the error.	Nurse/Director/Designee will audit medication administration to ensure accuracy of residents of medication administration at least weekly x 4 weeks, monthly x 3 months or as needed.	Implementation Date:9/18/26 Completion **Date:** 10/6/26 Responsible Party: HCC HCC/Director
A 152	**481-67.5(231B,231C,231D) Medications.** **67.5(2)?Each program shall follow its own** **written medication policy, including the following:** **traditionally by the program:** (3) Medications and treatments will be administered as prescribed by	Current medication delegated staff will receive education regarding medication administration by 10/31/2026.	Nurse/Director/Designee will audit medication administration to ensure accuracy of residents of medication administration at least weekly x 4 weeks, monthly x 3 months or as needed.	

	the tenant's physician, advanced registered nurse practitioner or PA. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, staff failed to administer medications in accordance with physician orders. This pertained to 1 of 3 tenants (Tenant #14) observed during medication administration in the memory care unit and 1 of 1 tenant (Tenant #12) who required emergency department evaluation following a medication error.			
A 191	**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 observations, interviews, and record review, the Program failed to consistently provide an adequate number of appropriately trained staff to meet tenants' needs. This pertained to 2 of tenants 2 (Tenants #1 and #7) reviewed for staff response to personal emergency response system.	All current staff received education on Door Alarm Response, Pendant Response, Exception Log by 9/28/26.	Nurse/Director/Designee shall Audit 4 times weekly for 4 weeks, monthly and as needed of Pendant/Door Alarm Response and Exception Log.	
A 199	**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**	Supervision of Staff expectations will be reviewed with Nurse/Executive Director by 11/1/2026.	New staff will have supervision of staff completed by nurse/designee within 30 days of hire and as needed thereafter.	

	competent to meet the individual needs of tenants. Nurse delegation shall include the following: **e. The program's nurse(s) will provide direct or indirect supervision of all direct care staff as necessary in the professional judgment of the program's nurse(s) and in accordance with the needs of the tenants and staff.** This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the Program's nurse failed to consistently provide adequate supervision to ensure staff were competent to meet tenant needs. This pertained to 3 of 6 tenants who resided in the assisted living part of the building		Nurse/Director/Designee to provide supervision of cares and/or med passes daily, weekly, monthly as needed.	
A 268	**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	Nurse/Director education will be reviewed regarding significant resident changes and documentation by exception process by 11/1/2026.	Nurse/Director/Designee will review incidents and/or communications from staff to ensure documentation by exception expectations are met weekly x 4 weeks, monthly x 2 months and as needed, or until substantial compliance is achieved.	Implementation Date: 10/6/26 Completion Date: 10/30/26 Responsible party" **Director/HCC** Implementation Date: 10/9/26 Completion Date: ongoing Responsible party" **Director/HCC** Implementation Date: 10/9/26 Completion Date: ongoing

	Program failed to document nurse 's notes by exception			Responsible party" **Director**
A 366	**481-69.32(2) Life Safety481-69.32(231C)** Life safety-emergency policies and procedures and structural safety requirements. 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure an operating alarm system connected to all exit doors. This pertained to 2 of 2 tenants (Tenant #4 and #5) who eloped through an unalarmed door and potentially all tenants who resided in the memory care unit	All staff will receive education Regarding functionality of the operating alarm system and purpose by 11/1/2026. This will include proper doors to utilize (and the identification of the door), that propping of the doors is unacceptable and may lead up to termination.	New employees shall receive education regarding the functionality of the operating alarm system within 30 days of hire or prior to working independently. Nurse/Director/Designee shall audit community exits to ensure properly secured and the functionality of the operating alarm system four times per week x 4 weeks, monthly as needed or until compliance is maintained.	Implementation Date: March 2026 Completion Date: March 2026 Responsible party" **Director/HCC** Completed by Director while surveyor was onsite Implemented while onsite with surveyor
A 385	**481-69.34(231C) Activities**. The program shall have a policy related to activities, including the following: 69.34(1) The program will provide appropriate activities for each tenant reflecting individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skills by	Memory Care and Assisted Living will have separated Activities Calander and published by 10/31/26.	Director/LEC/Designee shall audit activities occurring for assisted living and memory care at least 3 times weekly x 4 weeks and until consistent	Implementation Date: October 2026 Completion Date: 9/20/26 Responsible party" **Director/LEC**

	providing opportunities for a variety of types and levels of involvement.			
A 391	**481-69.35(231C) Structural requirements.** 69.35(1) General requirements. b. The buildings and grounds will be well-maintained, clean, safe and sanitary.	T6 apartment and carpet was cleaned at time of voiced concern. Carpet replacement quotes to be collected by 11/1/26. Staff shall receive education regarding resident environments being well-kept and maintained, trash removal expectations and carpet cleaning checklist schedule and as needed by 11/1/26. All residents housekeeping schedules will be reviewed to ensure schedule is in place by 11/1/26.	Director/Designee shall ensure a Monthly Checklist for Carpet Cleaning is in place and followed weekly, monthly or as needed. Director/Designee will audit to ensure housekeeping tasks are completed and trash is removed by schedule and as needed. Audit 4 times weekly x 4 weeks, monthly x 2 months and as needed.	Implementation Date: October 2026 Completion Date: 9/20/26 Responsible party" **Director/ Housekeeper** **Completed** Implementation Date: 9/28/26 Completion Date: ongoing Responsible party" **Director/ Housekeeper**