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
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

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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: 25 Tenants with cognitive impairment: 11 Total census: 36 There were no regulatory insufficiencies cited during the investigation of Complaint #131766-C. The following regulatory insufficiencies were cited during the investigation of Complaints #131802-C, #131641-C, #131617-C, #131565-C, the revisit to determine progress in correcting Citation #11060 and the recertification visit completed to determine compliance with the licensing rules for an assisted living program for people with dementia.	A 000		
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 care and treatment to 2 of 7 current tenants reviewed (Tenant #2 and Tenant #5) and 3 of 4 discharged tenants reviewed (Tenant C1, Tenant C2 and Tenant C3) and potentially all tenants. Findings	A 122		

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A 122	Continued From page 1 follow: 1. Record review on 8/5/26 revealedTenant C1 was a 76-year-old male who visited the wound clinic on 1/30/26 for an evaluation of a nonhealing ulcer on his buttock. He had additional wounds present to the left lower leg and right third toe. His wife believed the wounds were present for about one week. He had mild relief with the topical ointments. He also changed positions often. Tenant C1 sat on an eggcrate cushion. Record review on 8/5/26 revealed Tenant C1's Service plan dated 1/9/26 revealed he was totally dependent on staff to administer and order his medication. Tenant C1 received moderate nursing services as the Health and Wellness Director (HWD) ordered supplies, scheduled appointments and coordinated with his physician and outside providers such as his wound provider. He required skin care provided by licensed and unlicensed staff who were delegated by the nurse. Staff should refer to the Medication Administration Record (MAR) for specifics. He could wash his left foot daily with soapy water and use lotion for dry skin. He had a mild orientation issue that did not interfere with functioning in familiar surroundings. Tenant C1 could have some short-term memory issues. Record review of wound clinic notes revealed treatment ordered at the 1/30/26 wound clinic visit for the Stage II ulcer on his buttock changed from mupirocin and mometason creams to Medihoney. He did not need to cover with a Band-Aid but a piece of gauze could be placed over the wound to keep it from sticking to undergarments. It should be applied daily and as needed after bowel movements. Staff should clean the area with soap, water and pat dry.	A 122		

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A 122	Continued From page 2 There was a nonhealing ulcer on his left lower leg which should be covered with gauze to protect the skin. He could wear Tubigrips to his bilateral lower legs each day, but should consider switching to compression stockings. Wash daily with soap and water and pat dry. Apply Prisma to the open area on the right third medial toe and buddy tape to the next toe. Change on bath days. Change positions at least every hour. Consider a ROHO cushion for the wheelchair instead of an egg carton cushion. A review of Tenant C1's February 2026 MAR was conducted on 7/16/26 at 11:16 AM with the Corporate Director of Operations (CDO), due to the Program switched to a new electronic record system and being unable to print out the MAR. The Program continued to treat a wound to his right heel (though it was not identified at the wound clinic). The Program failed to administer a band aid to his heel on: 2/12, 2/13, 2/14, 2/20, 2/23, 2/24, 2/25, 2/26, 2/27 and 2/28. He did not receive Diclofenac gel to his right shin on 2/14, 2/15 and 2/21. He did not receive the ordered treatment to his left lower leg on 2/12 to 2/28. Tenant C1 had a wound to his left buttock and did not receive the treatment from 2/12 to 2/28. Staff were to apply Tubigrips to Tenant C1's legs daily but they were not applied from 2/11 to 2/28. Treatment to Tenant C1's wound to his right third toe was not completed from 2/15 to 2/28. Tenant C1 returned to the Wound clinic on 2/27/26. He sat on a donut cushion to offload his buttocks and wore Tubigrips for compression. He did not have a dressing on his right third toe. The Stage II pressure ulcer to his buttock was healing nicely with only a very small open wound noted. The skin ulcer to the third toe of the right foot was limited to breakdown of skin with no open	A 122		

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A 122	Continued From page 3	A 122		

wounds. There were no open wounds to his left lower extremity but he still had 2+ edema. Treatment orders changed to use Medihoney to the left buttock wound, cover with gauze and tape, war compression stockings or Tubigrip daily and remove at night, and no dressing was needed to the left lower leg or right third toe.

Requests were made to the Executive Director for Tenant C1's March MAR on 7/16/26, 7/21/26 and 8/7/26 but a copy was not received in a format the surveyor could open.

Review of a Progress Note on 8/5/26 indicated Tenant C1's bilateral lower extremities were red and painful on 3/15/26. The HWD encouraged him to go to the Emergency Room (ER). His wife took him. A review of hospital records revealed Tenant C1 went to the ER on 3/15/26 due to concerns for cellulitis of his lower extremity. He reported for the prior two to three days he experienced erythema and swelling of the left lower extremity and was starting to notice some redness in the right lower extremity as well. It was very tender to the touch. He had a history of Type II diabetes, peripheral neuropathy, obstructive sleep apnea, atrial fibrillation, hyperlipidemia and hypertension and amputation of the right fifth toe. He was predominantly wheelchair bound with a history of uncontrolled diabetes and recurrent lower extremity infection.

During his hospitalization Tenant C1 experienced severe anxiety and agitation, Methicillin-resistant Staphylococcus aureus (MRSA) positive lower extremity cellulitis and sepsis with leukocytosis. Tenant C1 developed Acute hypoxic respiratory failure secondary to daptomycin toxicity. His family noted he displayed some signs of dementia. He was provided IV steroids and would

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A 122	Continued From page 4	A 122		

taper off Prednisone upon his return to the Program. Tenant C1 was on high-dose short acting insulin along with Lantus. The Prednisone could induce hyperglycemia (high blood sugar) but this would improve with the Prednisone taper. He did not adhere to the recommended low carbohydrate diet as his family brought in high carbohydrate snacks and drinks. Tenant C1 was discharged with orders to check his blood sugar four times daily (before meals and at bedtime). His insulin should be held if his blood sugar was less than 120 or if he did not eat a meal. Tenant C1's needs were not reassessed by the HWD following this hospitalization.

Record review on 7/16/26 of the April MAR revealed instructions for staff to inject 50 units of Humulin (insulin) 3 times daily before meals. There were no instructions about holding the insulin if his blood sugar was low or if he did not eat a meal.

In a wound clinic note dated 4/6/26, the clinician noted his 2/27/26 visit his wounds were minimal. However, when he entered the hospital on 3/15/26 he had multiple wounds to include the left buttock, right buttock and right heel. The wife shared she may have caused a wound to his scrotum by using tape there. He was using a doughnut cushion for offloading. He had been incontinent of bowel recently which was causing pain to his buttocks and scrotum. Since returning home his arms and legs were swollen and he didn't feel well.

Treatment orders included: apply a thin layer of TheraHoney to buttock wounds daily and as needed. Apply Prisma to the right lower leg wound and cover with Mepilex border. Change dressing every two to three days. Continue

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A 122	Continued From page 5 wearing Tubigrip to bilateral lower legs. Reposition frequently throughout the day to relieve pressure. Sitting on the donut pillow was not recommended and he should switch to a ROHO cushion. Tenant C1 was edematous and his oxygen level was 94. He agreed to go to the ER. Tenant C1 presented at the ER on 4/6/26. He was assessed and his symptoms were determined to be related to his chronic medical conditions. He should follow up with his primary care provider (PCP) if his symptoms continued. The Program had no notes about the wound clinic visit or ER visit. The new wound orders were not added to the April MAR. There was no documentation Tenant C1's PCP was notified of his change of condition. Further review of progress notes revealed Tenant C1 received insulin the night of 4/7/26. Staff documented he refused the 8:00 AM dose of insulin (and all his morning medications) at 1:34 PM on 4/8/26. The HWD documented in the progress notes on 4/8/26 at 11:03 AM the Med Technician reported to her Tenant C1 missed his morning medication as he was sleeping in his apartment. The Med Technician said she raised her voice to try and wake him up but he wouldn't wake up. The HWD instructed the Med Technician to check his blood sugar and it was 24 (very low). The HWD administered 1 milliliter (ml) of IM Glucagon and called EMS. He was transported to the ER. The HWD called the Emergency Room (ER) and learned he would be admitted for altered mental status, hypoglycemia and urinary tract infection. The April MAR did not show documentation of staff checking Tenant C1's blood glucose four times daily as ordered when he was discharged from the hospital on 3/30/26.	A 122		

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A 122	Continued From page 6 The Executive Director, Regional Director of Clinical Operations and Corporate Director of Operations were asked in an email to provide evidence staff completed Tenant C1's blood glucose readings on 8/7/26, but did not respond to the request. Record review on 8/7/26 revealed the Emergency Documentation indicated Tenant C1 arrived at the ER on 4/8/26 at 11:50 AM. Upon arrival he was moaning with his eyes opened, but not following commands or providing meaningful communication. His wife arrived at 12:30 PM and reported they went out to eat the previous evening and she took him back to the Program. He seemed normal. Tenant C1 continued to display agitation in the ER, yelling at staff and striking his wife. He was transferred to another hospital. A further review of progress notes on 7/16/26 indicated the HWD went to the hospital on 4/20/26 to assess Tenant C1 for return to the Program. She determined he required a minimum assistance of two people.. He had a significant cognitive decline, did not respond to much and was frequently unable to take his medication. He was discharged from the Program. Hospital records reviewed on 8/7/26 revealed Tenant C1 discharged on 5/1/26 to a higher level of care. Diagnoses upon discharge included hypoglycemic encephalopathy, altered mental status, sepsis with leukocytosis due to urinary tract infection, cellulitis of the bilateral lower extremities and right upper extremity edema. The discharge instructions noted Tenant C1 would be discharged on a sliding scale insulin due to his hard to control blood sugars and to prevent further hypoglycemia. He had a high risk of	A 122		

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A 122	Continued From page 7	A 122		

readmission due to progressive dementia (not a noted issue prior to his 3/15/26 hospitalization).

During an interview on 7/15/26 at 3:02 PM Staff C recalled working on 4/8/26. She went in to check on Tenant C1 later in the morning on 4/8/26 and he was not responsive. Staff C was not the Med Technician, she went in to provide a visual check. When she could not get him to wake up she got the HWD and then contacted 911. Tenant C1 did not return to the Program. The HWD and Staff O, who should have administered Tenant C1's 8:00 medication the morning of 4/8/26, no longer worked at the Program. She remembered Tenant C1 complained of leg pain all the time. She didn't know if he had sores on his legs as he always wore pants.

When interviewed on 7/15/26 at 4:00 PM Staff N recalled some staff applied treatments to Tenant C1's legs and other staff did not. She recalled Staff O did not apply Tenant C1's wound treatments. The treatments took 20 to30 minutes to apply. Tenant C1 would refuse at times so Staff O would either mark refused or she administered them even if she did not do so. Staff N and others told the HWD about this but nothing was done.

When interviewed on 7/21/26 at 12:10 PM Staff K explained she heard Tenant C1 was not getting his dressings applied in the morning. These were generally applied in the morning and she worked at night. When she went to remove his Tubigrips at night they often weren't on. Some of the workers would say they didn't have time to apply them.

When interviewed on 7/15/26 at 11:15 AM Staff L stated she entered Tenant C1's apartment and he asked her to apply his ointments and dressings

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A 122	Continued From page 8	A 122		

because no one else had done so. He reported his legs were killing him. She asked Staff O to show her how to do these tasks because she did not know how to do them.

Interviews and a review of MARs revealed staff did not reliably apply the treatments to Tenant C1's wounds. Tenant C1 presented to the wound clinic, ER and hospital reporting pain in his extremities lasting days or a week before seeking care. There was no evidence these symptoms were identified by Program staff who should have seen his wounds daily or addressed by the HWD. Tenant C1did not have his needs reassessed when he returned from the hospital on 3/30/26 or from the ER on 4/6/26 after experiencing cellulitis, uncontrollable blood sugar, signs of dementia and overall poor health. He ended up being hospitalized on 4/8/26 with extremely low blood sugar and upon discharge had a significant cognitive decline and required the assistance of two staff for transfers. There was no evidence staff monitored or checked his blood glucose levels as ordered, including on the morning of 4/8/26, to prevent hyperglycemia or hypoglycemia.

2. a. Record review on 7/16/26 of Tenant C3's Admission note, dated 1/6/26, indicated he was a 73 year old male with a history of Parkinson's Disease who presented to the outpatient neurosurgery clinic for replacement of the battery of his Deep Brain Stimulator (DBS). His diagnoses included arthritis, benign prostatic hyperplasia, chronic obstructive pulmonary disease, depression, diabetes mellitus, type two, history of skin ulcer of the left lower leg with fat layer exposed (5/4/23) and wound infection (6/15/18).

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A 122	Continued From page 9 During the procedure, completed on 1/6/26, he was taken to the operating room. The subcutaneous tissue was opened, the battery was removed and a new battery was connected. The wound was irrigated and vancomycin powder was applied. Closure was performed in a multilayer fashion with a vicryl suture. The skin was closed with Dermabond skin glue and a sterile dressing was applied. Tenant C3 was provided with instructions to keep the wound covered for the first 3 days. He could run water over the wound after this time. He should not scrub the wound for two weeks following surgery. He could shower and pat the wound dry. His stitches were absorbable and did not need to be removed. The skin glue would flake off on its own. Record review on 7/21/26 revealed a Staff to Nurse Communication dated 1/13/26 at 9:30 (AM or PM not noted on the form) alerted the HWD Tenant C3 refused to shower as he did not want to get the patch wet from his surgery. The HWD responded in writing on 1/16/26 she spoke with Tenant C3's family and it was okay to get it wet. Continued record review revealed an Office Visit note dated 3/3/26 indicated since Tenant C3 had the battery on his IPG (Implantable Pulse Generator) replaced on 1/6/26. Today he still had the original band aide on his IPG site during the visit for he was told to keep the Band-Aid in place and not get it wet. The band aid looked dirty and was removed by the provider. The patient's left chest incision was a bit red but dry and intact. During an interview on 7/15/26 at 3:02 PM Staff C reported giving Tenant C3 a shower every Friday. She asked the HWD about the dressing and was told it should remain on until it fell off.	A 122		

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A 122	Continued From page 10 When interviewed on 7/20/26 at 1:40 PM the Regional Director of Operations reported Tenant C3's bandage should have been removed after three days. The HWD should have requested the clinic records if she was unclear of the instructions from the physician. b. Tenant C3's Resident Assessment and Service Plan written on 3/5/26 noted he required verbal prompts and cues with toileting due to his tremors. Staff were to provide toileting assistance one to three times per week. He wore incontinence garments and used a urinal. It noted he struggled with making it to the toilet on time and urinated on the floor of his apartment unintentionally. Tenant C3 received routine housekeeping services and daily trash removal. His skin condition was described as normal, although his upper and lower extremities required staff to apply Aquaphor. He had scattered edema, flaky dry skin and ecchymosis. Tenant C3 did not use any wraps or hose to address his edema. He required staff assistance twice weekly with showering. He was able to express pain but had no pain. Tenant C3 made 0-2 errors on the neurocognitive evaluation indicating normal intellectual functioning. There was no mention of him refusing assistance from staff. A review of observation notes on 7/16/26 revealed the following: - On 3/9/26 Tenant C3 refused a shower. Staff strongly encouraged him to take one but he said he was too tired. - On 3/20/26 his bilateral extremities were red and warm to the touch from ankle to mid-calf. The left lower extremity had a fluid filled blister.	A 122		

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A 122	Continued From page 11	A 122		

The HWD encouraged him to get evaluated but he refused. His PCP and wife were notified. A review of the MAR indicated the Program received an order for Ace bandages to his bilateral lower legs which started on 3/24/26.

- On 4/7/26 at 6:50 PM Tenant C3 fell in his room and was found on the ground in front of his toilet. The HWD was called to his room. He reported pain to his lower back and bilateral lower extremities on 4/9/26. The HWD contacted Tenant C3's PCP with a request for pain management. On 4/10/26 staff reported he could not complete his activities of daily living himself and refused a shower (although staff documented on the task sheet a shower was completed). The HWD contacted the PCP's office again and left a message. On 4/13/26, Tenant C3 reported discomfort when walking to his posterior left lower extremity just above the knee which was a 5 out of 10 when walking. He had no pain when sitting. His PCP was again notified. A review of Tenant C3's April MAR revealed no over the counter or prescription pain medication administered during this time period. The PCP responded to the HWD's fax from 4/13/26 about his pain on 5/6/26 and asked her to monitor the situation.

"A review of the April 2026 MAR revealed that starting on 4/10 and 4/11, after his pain started from the fall, Tenant C3 refused the Ace bandages to his lower legs. Staff documented, beginning on 4/12/26, that the bandages were "on hold per the nurse's orders," "nurses orders to hold off on wrapping legs," "discontinued," and "nurse's orders holding off on wrapping."

- Tenant C3 had many dates on the April, 2026 MAR and May, 2026 MAR documented as refusing application of his Aquaphor ointment

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A 122	Continued From page 12	A 122		

which staff were to apply to his legs twice daily as needed. On 4/12, 4/14, 4/16, 4/21, 4/25, 5/3, 5/5, 5/9, 5/10, 5/14, 5/18 it was documented as not administered as it was on hold per the doctor's orders. Other dates through the month staff did not administer the Aquaphor ointment noting Tenant C3 refused the treatment. Staff applied the ointment to his legs twice between 5/9/26 and 5/30/26. There was no indication his PCP was contacted to inform him the tenant was not getting the ordered treatment.

- He began taking Cephalexin twice daily on 5/21/26 as seen on the May MAR (no reason noted in the observation notes). On 5/26/26 he was seen by the Nurse Practitioner for a red, warm open area on his left lower extremity. The Cephalexin was increased to four times daily. Staff were to cleanse his lower left extremity with soap and water, apply telfa to the open lesions, wrap with kerlix and change daily. It was documented on the May MAR the wound treatment was self-administered.

- Tenant C3 moved out of the building on 5/29/26.

Record review on 7/20/26 and 7/21/26 of Monthly task logs, Care Tracking Sheets and Consumer-Directed Attendant Care Daily Service Records from March, 2026 - May 2026 indicated Tenant C3 received the following personal care which was identified on his assessment and service plan:

March 2026:
Housekeeping - completed on 3/3, 3/10, 3/15, 3/17, 3/19, 3/29
Laundry - completed on 3/3, 3/10, 317
Shower - completed on 3/6, 3/10, 3/15, 3/17, 3/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 122	Continued From page 13 April 2026: Weekly housekeeping - completed on 4/7, 4/14 Laundry - completed on 4/7, 4/14 Shower - completed on 4/7, 4/10, 4/17, 4/24 May 2026: Shower - completed on 5/8, 5/19, 5/26 During an interview on 7/15/26 at 8:30 AM and 8/4/26 at 11:50 AM Tenant C3's daughter reported when they took her father for his follow-up visit the neurologist said she had seen a lot over the years but nothing like that. They were paying the Program to provide her father with regular showers and could not understand why these weren't being done. After the appointment she spoke with the HWD and was told she did not receive instructions for wound care. Her father's apartment was not getting cleaned regularly. She was told they would have someone clean the bathroom daily as he urinated on the floor. This was not done. His legs were swelling and oozing at times. Due to her father's functional limitations, he would not have been able to self-administer his wound care from 5/26/26 through discharge. When they gave a 30-day notice of discharge she felt like her father received worse care. Now that her father is home he is doing better and has no swelling in his legs. When interviewed on 8/4/26 at 12:10 PM Tenant C3's wife explained there were a couple of times she noticed her husband had red and swollen legs. She called the Program to alert them to the condition multiple times but did not receive a call back. The wife was aware of the seriousness of the condition as a few years ago he had edema and developed a wound which broke the skin open from his knee to the ankle. Her husband had to go to the wound clinic and it took forever to	A 122		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 122	Continued From page 14	A 122		

heal. She knew the symptoms to watch for to prevent this from happening. When he developed the blisters and oozing places on his skin this time she went to Walgreens and bought patches similar to what he had at the wound clinic. The staff used this material on his legs (there is no evidence of this on the MAR). Her husband could be testy at times but it would surprise her to learn he refused to let staff apply Aquaphor lotion to his legs through most of April and May. When she looked at his legs, they did look dry and this could lead to the open areas on his skin. His wife did not believe she was told he was on an antibiotic or had ordered wound treatment when she brought him home.

When interviewed on 7/20/26 at 1:20 PM Staff A explained she noticed cleanliness issues with Tenant C3's apartment and person. The apartment had a strong odor. She was never directed to clean it more than once a week. When she went in to care for him, he commented it had been so long since he had help. His feet were swollen and cracked all over. It appeared as if his feet weren't getting taken care of at all. She tried to take care of all the tenants but there was only so much one person could do. When she learned he was moving it made sense to her.

When interviewed on 7/21/26 at 10:30 AM Staff D recalled Tenant C3's legs looked as if they had eczema or psoriasis on them. When she was training, she never saw anyone apply lotion to his legs, they told her he didn't have any lotion. His apartment smelled of urine but not as strongly as Tenant #5's apartment. People didn't care to go into the apartment due to the odor. She didn't blame Tenant C3 for leaving as no staff wanted to go in the apartment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 122	Continued From page 15 When interviewed on 7/15/26 at 3:02 PM Staff C described there were issues with getting people showers as scheduled until May, 2026 as only one person was scheduled in the front of the building. They didn't have a housekeeper at the time so the aides were responsible for doing cares, administering medications, answering pendants and cleaning apartments. Tenant C3's apartment smelled of urine and was always nasty. During an exit meeting on 7/23/26 at 10:50 AM with the Executive Director, CDO and Regional Director of Clinical Operations confirmed the findings. On 8/5/26 at 8:52 AM the Regional Director of Clinical Operations confirmed the Program failed to obtain an order to start Ace Bandages, discontinue the Ace bandages and discontinue the Aquaphor ointment. 3. Record review on 7/16/26 of Tenant #2's face sheet identified she was a 66-year-old female diagnosed with a fall with pelvic fracture, alcohol abuse, TIA, lumbar pain with sciatica and chronic pain. a. A review of Tenant #2's July MAR revealed staff administered her the following medication on a PRN or as needed basis: Butalbital-Acetaminophen-Caffeine 50-325-40, one tablet every 6 hours as needed for pain (a prescription combination used to treat tension headaches caused by muscle contractions, Butalbital is a barbiturate) and Hydrocodone/Apap tab 7.5-325, take 1 tablet four times daily as needed (a prescription painkiller, hydrocodone is an opioid). The July MAR showed Tenant #2 used both medications anywhere from 1-4 times daily for pain. The Program tracked the length of time it took for	A 122		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 122	Continued From page 16 staff to respond when tenants pushed their pendants for assistance on a Device Activity Report. A review of this report on 7/21/26 revealed during the period of 6/20/26 to 7/21/26, Tenant #2 pushed her pendant 115 times. It took staff an average of 16 minutes and 44 seconds to respond to her pendant. The following instances were dates when it took staff more than 20 minutes to respond to Tenant #2's page for assistance: 6/20/26: 39 minutes 6/22/26: 24 minutes 6/23/26 at 5:56 AM: 41 minutes, 11:31 AM: 36 minutes 6/24/26: 31 minutes 6/26/26 at 2:15 AM: 39 minutes, 1:23 PM: 24 minutes, 4:26 PM: 50 minutes 6/28/26 at 5:19 AM: 34 minutes, 3:51 PM: 105 minutes 6/29/26 at 1:39 AM: 21 minutes, 2:34 PM: 34 minutes, 7:27 PM: 69 minutes 7/1/26 at 4:30 PM: 51 minutes 7/3/26: 22 minutes 7/7/26 at 7:42 AM: 24 minutes, 8:51 AM: 38 minutes, 5:32 PM: 30 minutes 7/8/26 at 5:17 AM: 21 minutes, 5:13 PM: 32 minutes, 10:24 PM: 45 minutes 7/12/26 at 11:57 AM, 5:29 PM: 26 minutes 7/13/26 at 12:45 AM: 33 minutes, 1:25 PM: 36 minutes 7/14/26: 25 minutes 7/15/26 at 7:36 AM: 41 minutes, 9:43 AM: 23 minutes 7/17/26: 61 minutes 7/19/26: 108 minutes During an interview on 7/15/26 at 3:02 PM Staff C	A 122		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 122	Continued From page 17	A 122		

reported concerns Tenant #2 was overly dependent on her pain medication. She would utilize her pendant requesting PRN medication every four hours on the dot. Sometimes she wondered if Tenant #2 really needed the medication or not so she would not rush to her room to administer the medication.

When interviewed on 7/20/26 at 1:20 PM Staff A reported Tenant #2 would report her pain level as a 7/8 out of 10 to get her pain medication every four hours. Staff A would question if Tenant #2 really needed her pain medicine as it seemed like an addiction to her. She would drink beer and lay in bed all day. Tenant #2 told a co-worker she would check the medication cart as she walked by to ensure it was locked. Staff A supposed this was so she could get additional medication.

Staff L was a former employee. She recalled a time when she entered Tenant #2's apartment to find her crying due to not receiving her pain medication. When Staff L asked her co-workers why Tenant #2 had not been administered her PRN medication, they said they were to put her off for an hour because she was pill-seeking.

During an interview on 7/21/26 at 12:05 PM the CDO explained there was no policy on how quickly staff should respond to pendant requests but she thought it should be within 10-15 minutes.

During an exit meeting on 7/23/26 at 10:50 AM the Executive Director, CDO and Regional Director of Operations confirmed Tenant #2 was entitled to receive her PRN medication as ordered by her physician.

The Program failed to ensure staff were properly trained in substance abuse issues to provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 122	Continued From page 18	A 122		

adequate care to Tenant #2. Her medical provider prescribed her PRN to be administered every four hours or four times a day. It was not for staff to decide if a medication should be administered in a different manner.

b. A review of observation notes for Tenant #2 revealed the following:

- She was observed with a harsh, productive cough with yellow mucus on 3/31/26. She was assessed and wheezing was discovered in her bilateral lung fields. An antibiotic was prescribed for seven days.

- She completed her antibiotic on 4/7/26 but a harsh, productive cough continued. She continued to take an expectorant and an albuterol inhaler as needed.

- The PCP ordered a new antibiotic for Tenant #2 on 5/5/26.

- Tenant #2 met with her PCP on 6/8/26 and discussed her chronic cough. A new order was written for a chest x-ray.

- She reported dryness and cracking skin to the bilateral bottoms of her feet on 6/22/26 as well as coughing and back pain. New orders were received for Aquaphor, Biofreeze and Tessalon Perles.

A review of Tenant #2's July MAR revealed Ipratropium/Sol Albuter (Ipratropium and albuterol inhalation solution), inhale 1 vial via nebulizer every six hours was added to the MAR on 7/6/26. However, Tenant #2 did not receive the medication through at least 7/22/26. Staff documented on the MAR, "medication not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 122	Continued From page 19 available" and "does not have the machine". Observation of a medication pass for Tenant #2 on 7/21/26 at 1:50 PM. Staff D reported she was unable to administer the Ipratropium/Sol Albuter as the tenant did not have a nebulizer. Staff D reported Tenant #2 did have a cough. During the medication pass Tenant #2 stated she did not know why the nebulizer hadn't been delivered. She was told there was an issue with the pharmacy but hadn't been provided with any additional information. Tenant #2 experienced a coughing episode during the conversation. The Program failed to take steps to get a nebulizer when it was prescribed for Tenant #2 who had been experiencing a harsh cough for over three months. 4. Record review on 7/22/26 for Tenant #5 noted she had a service plan dated 1/5/26. She was independent with toileting but had a history of urinary tract infections and used a urinary pad. Tenant #5 received routine housekeeping and laundry services. When interviewed on 7/20/26 at 1:20 PM Staff A described the condition of Tenant #5's room as a biohazard. She was known to urinate on her clothing and then hang the soiled clothing up. Her carpet needed deep cleaning. Tenant #5 was very independent so staff were only in her apartment to take out her trash and collect laundry. During an interview on 7/21/26 at 8:05 AM Staff J reported when she entered Tenant #5's apartment it was very dirty and had a strong odor. The clothing on her floor was soiled with urine. When interviewed on 7/21/26 at 12:10 PM Staff K	A 122		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 122	Continued From page 20	A 122		

explained she was able to smell urine coming from Tenant #5's apartment when walking down the hall. She was not sure if the tenant needed more assistance with cares as the tenant was very reserved. Staff K could not visibly see signs of Tenant #5's incontinence but could smell the odor when she was in her presence.

During an interview on 7/21/26 at 10:30 AM Staff D stated Tenant #5's apartment was stinky. The tenant would leave her soiled clothing sitting in her bathroom. Staff D would encourage her co-workers to wash Tenant #5's clothing twice to try and rid them of the smell of urine. When Tenant #5 came to meals she would smell of urine.
When walking through the building on 7/15/26, 7/16/26, 7/21/26 and 7/23/26 a smell of urine was present in the vicinity of Tenant #5's apartment. During a tour of the building on 7/21/26 at 9:05 AM the Executive Director confirmed she was aware of the odor on that date.

There was no evidence of interventions being put in place to address Tenant #5's incontinence and the manner in which it was likely becoming a dignity issue.

During an interview on 7/23/25 at 10:05 AM the Regional Director of Clinical Operations reported she was not aware of these issues but would address them when she returned to the community.

5. Record review on 7/16/26 of a preadmission Comprehensive Assessment for Tenant C2 dated 2/9/26 revealed he was admitted from another assisted living program with a planned move in date of 2/23/26. He used a walker and wheelchair for mobility. Tenant C2 required standby

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 122	Continued From page 21	A 122		

assistance when transferring. He had experienced 3 or more falls within the previous 90 days. Tenant C2 was diagnosed with Lewy Body Dementia with tremors. The HWD took Tenant C2's vitals but did not obtain his height or weight.

A Care Plan was developed on 2/23/26, his move-in date, which noted Tenant C2 required the assistance of 2 staff for transfers. They should use a gait belt and grab bar.

Review on 7/16/26 of the Nurse Practitioner ' s Progress note dated 3/2/26 identified he was experiencing ongoing, worsening evening delusions and hallucinations related to Lewy body dementia. He was recently hospitalized for dehydration. Staff reported he experienced more than 4 falls since admission. He required 2-3 staff for assistance with transfers.

Tenant C2 discharged from the Program on 4/15/26.

During an interview on 7/15/26 at 8:10 AM Staff M recalled Tenant C2 was a large man, perhaps 400 pounds, who had frequent falls. There were often only two caregivers working in the building, but even 2-3 staff could not get him up. When he was on the floor, they had to call the fire department to get him up.

When interviewed on 7/15/26 at 4:00 PM Staff N explained it would routinely take 4 staff to lift Tenant C2 from the time he moved to the Program. He would slip from his chair to the floor.

The Program admitted a tenant who required the assistance of two staff for transfers. Program staff were unable to provide adequate services to Tenant C2 and had to call the fire department to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 122	Continued From page 22	A 122		

lift him from the floor. They were unable to meet his needs on a routine basis.

When interviewed on 7/16/26 at 11:16 AM the Regional Director of Clinical Operations confirmed Tenant C2 should not have been admitted to the Program if he was a two-person transfer, however she was not working at the Program at the time he resided there.

6. During an observation on the dementia-specific unit on 7/15/26 at 11:45 AM there were 6 tenants sitting in the dining room. Five tenants received the regular meal and one tenant had an alternative meal. There were two additional tenants who needed the main dish, cottage pie, but no food was available. There was a sufficient amount of dessert. Staff requested food at 11:45 AM and again at 11:52 AM. Extra food was brought at 11:54 AM.

When interviewed on 7/15/26 at 11:12 AM Staff L reported the kitchen frequently did not send enough food to the dementia specific unit to meet the needs of the tenants. There were men who would ask for additional food and the kitchen would not send it back.

When interviewed on 7/16/26 at 8:55 AM Staff P explained she believed there used to be issues with the former cook not sending enough food to the dementia specific unit but she thought for the most part things had improved.

When interviewed on 7/15/26 at 8:10 AM Staff M reported in the past there were times the kitchen wouldn't send back enough food for the tenants living on the dementia specific unit. The kitchen staff would get upset when they asked for more food. They expected the tenants to eat half meals

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 122	Continued From page 23 and that didn't work. Observations on 7/16/26 at 11:40 AM there was a sufficient amount of food sent to the dementia specific unit for lunch. A plate of food sat on the table when Tenant #8 arrived and sat down in that spot. She reported her food was cold. Tenant #9 also indicated her food was cold. A review of the Daily Temp log indicated the Chicken Alfredo was 105 degrees when the employee checked the temperature. The biscuit was 48.3 degrees and the watermelon and cucumber were 57 degrees. The food was on a warming cart that was not plugged in. A further review of selected Daily Temp Logs from 6/1/26 - 7/20/26 revealed the following temperatures in degrees Fahrenheit: 6/1/26: bacon - 88.5, tomato soup - 105.2, grilled cheese - 104 6/9/26: pork tenderloin sandwich - 97.8, tater tot - 101.2, cold sandwich - 71.9 6/21/26: sausage patty - 123.8, bacon - 113.9, diced pork - 101.3, broccoli and carrot mix - 99.1, potato wedges - 109.2, ravioli - 122.4, fruit cocktail - 69.9 7/15/26: cottage cheese - 42, butterscotch pudding - 60, cheese - 69.4, tomatoes - 53.2, eggs - 64.7, carrots - 55.7, lettuce - 46.7, onions - 61.9 7/17/26: salad bar - eggs 42, grapes - 49.1, watermelon salad - 45.9, cottage cheese - 46.8, shredded cheese - 57.8, peppers - 50.3, carrots - 51.2, lettuce - 50 7/18/26: yogurt - 57.9, mandarin oranges - 51.8 During a meeting with the Culinary Director and Executive Director on 7/16/26 at 12:10 PM, the Culinary Director reported there was no cord to	A 122		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 122	Continued From page 24 plug in the warming cart but one was on order. They would put a plan in place to ensure food was not taken to the dementia specific unit until all tenants are seated. Record review on 7/21/26 of the Program's Food Safety and Sanitation Policy (undated) noted cold foods would be maintained at 41 degrees or below and hot foods would be maintained at 135 degrees or above. During an interview on 7/21/26 at 8:25 AM the Executive Director reported a new plug arrived for the warming cart and was installed. She did not know how long the food temperatures were at an unacceptable level but they were talking as a team about ways to solve the problem.	A 122		
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 interview and record review the Program failed to ensure staff were properly trained to administer medication, potentially affecting all tenants who received medication administration services. Findings follow: Record review on 7/23/26 revealed the Program's Medication Competency Evaluation packet (effective 3/2025) revealed staff were trained on this information before administering medication. In order to properly administer medication to	A 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 25	A 191		

tenants they should follow steps to include the following:

Check the Medication Administration Record (MAR) and/or tenant chart for the appropriate order.

Read the MAR.
Find the correct bubble pack.
Before, during and after medication, check the six rights of medication administration: Right tenant, Right Medication,
Right Date, Right Time, Right Route, Right Dose.
Put medication in the medicine cup directly from the bubble pack.
Identify tenant by name.
Administer the correct medication to the correct tenant at the correct time using the correct route.
Document the administration on the MAR.

During an interview on 7/15/26 at 11:12 AM Staff L explained an employee who administered medication in the morning would take the PM bubble pack and provide these pills to the tenants. Staff L talked with the Health and Wellness Director (HWD) about the employee and how this resulted in her being unable to administer medication to tenants in the evening. Staff L would document things such as "not in the pill pack" or "not able to give".

When interviewed on 7/15/26 at 4:00 PM Staff N recalled employees saying staff were mixing up the night bubble packs with the day bubble packs. She did not know if staff were applying creams and treatments as ordered to the tenants as it was a timely process. Staff went to the former Executive Director and reported this information but nothing was ever done to address it. She would look at the documentation on the MAR and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 26	A 191		

it reflected the tenant refused the treatment. There were other times the staff might document the tenant received the treatment when she knew it did not occur.

When interviewed on 7/21/26 at 12:10 PM Staff K stated there were times when she did not have PM medication to administer to tenants. For a while it seemed as if it happened every other day for about a week. This went on for a "short stint". There were only one to two times she saw cups of medication left in tenant's apartments. Staff K believed the HWD talked with these employees.

When interviewed on 7/21/26 at 10:30 AM Staff D reported her medication training involved watching two current employees and the former HWD pass medication. One current employee would fill a number of cups of medications for various tenants, writing their initials on them and passing them to tenants. There were some tenants a person had to watch take their medication and others she could leave the medication in the apartment. It was okay to leave medication with Tenant #6.

During an interview on 7/20/26 at 1:20 PM Staff A reported some staff would mark "refuse" on tenant's lotions or creams because they had a history of refusing. She struggled to pass all the morning medication in the allotted time because she watched tenants take their medication and applied all the creams. Staff A was taught to set up medications in cups for all the tenants ahead of time. She now knows this is not the proper way to administer medication.

When interviewed on 7/20/26 at 3:37 PM the Regional Director of Clinical Operations reported it was not acceptable to set up medication for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 27 number of tenants prior to administration. Staff should not leave medication cups for tenants. If they provided the medication to tenants, they need to ensure the pills are being taken. Staff should not take pills from the PM bubble packs to give to tenants in the AM. Staff needed to document the appropriate cares and provide the physician ordered cares.	A 191		
A 201	481-67.9(4)g 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: 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 ensure there was a system for staff to communicate with the nurse during the months of February, March and April in 2026,	A 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 201	Continued From page 28 potentially affecting all tenants. Findings follow: Record review of a communication binder revealed there were entries throughout 2025 and January 2026. Staff began filling out forms informing the nurse of changes in the condition of tenants beginning in May, 2026 to the present. There were no entries during the months of February, March and April of 2026. During an interview on 7/21/26 at 2:40 PM the Corporate Director of Operations confirmed the Program failed to ensure there was a method for staff to communicate changes in tenant condition with the nurse during the months of February, March and April of 2026.	A 201		
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 nurses' notes were written by exception for 2 of 4 discharged tenants reviewed (Tenant C1 and Tenant C3). Findings	A 268		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 268	Continued From page 29	A 268		

follow:

1. Record review on 8/5/26 revealed Tenant C1 was seen at the wound clinic on 4/6/26. His wife shared she may have caused a wound to his scrotum by using tape there. He was using a doughnut cushion for offloading. He had been incontinent of bowel recently which was causing pain to his buttocks and scrotum. Since returning home his arms and legs were swollen and he didn't feel well.

Treatment orders included: apply a thin layer of TheraHoney to buttock wounds daily and as needed. Apply Prisma to the right lower leg wound and cover with Mepilex border. Change dressing every two to three days. Continue wearing Tubigrip to bilateral lower legs. Reposition frequently throughout the day to relieve pressure. Sitting on the donut pillow was not recommended and he should switch to a ROHO cushion. Tenant C1 was edematous and his oxygen level was 94. He agreed to go to the Emergency Room (ER).

Record review on 8/7/26 of ER records identified he presented at the ER on 4/6/26. He was assessed and his symptoms were determined to be related to his chronic medical conditions. He should follow up with his primary care provider if his symptoms continued.

There were no nursing notes about the wound clinic visit or ER visit.

2. Record review on 7/20/26 revealed Tenant C3's March, April and May Medication Administration Records (MARs) revealed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 268	Continued From page 30 - The addition of Ace bandages, wrap both legs starting from foot to the knee in the mornings and remove at bedtime added on 3/24/26. - Entries beginning on 4/12/26 and continuing through the month indicated the order for Ace bandages was on hold per nurse's orders. - Cephalexin Oral Capsule, 500 mg., take one capsule by mouth twice daily for 10 days beginning on 5/21/26. There were no nursing notes providing information about the addition of the Ace wraps or the order putting the Ace wraps on hold. There was no information as to why Tenant C3 started on Cephalexin on 5/21/26. When interviewed on 8/05/26 at 8:52 AM the Regional Director of Operations confirmed there was no information in the record about these.	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 complete incident	A 274		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 274	Continued From page 31	A 274		

reports for 2 of 3 tenants reviewed who received medication administration services (Tenant #2 and Tenant #3) and an unknown number of additional tenants. Findings follow:

1. Record review on 7/20/26 revealed observation notes for Tenant #2 dated 5/17/26 at 11:01 AM revealed staff called a nurse to report several tenants' 8:00 AM medications were late due to a previous staff member failing to administer. The reason they were not given was unknown. The nurse went through Tenant #2's medication list and advised the staff member to administer the pills.

2. Continued review revealed observation notes for Tenant #3 dated 5/17/26 at 11:01 AM revealed staff called a nurse to report several tenants' 8:00 AM medications were late due to a previous staff member failing to administer. The reason they were not given was unknown. The nurse went through Tenant #3's medication list and advised the staff member to administer the pills.

Record review on 7/22/26 of the Program's Medication policy 2.01 (effective 3/2025) included in the Medication Competency Evaluation packet. Staff were to consistently follow the six "Rights" for proper and accurate administration of medicines which included providing it at the right time. The most important concept about the "Six Rights" was a violation of any right constituted a medication administration error. Thus, if any mistake was made a medication error/incident report form must be completed and submitted to the nurse.

The Corporate Director of Operations provided an email with a list of incident reports and medication errors on 7/15/26 at 2:15 PM. The list did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 274	Continued From page 32 include any medication errors from 5/17/26. During an interview on 7/22/26 at 3:37 PM the Regional Director of Clinical Operations confirmed the Program failed to ensure medication error forms were completed for all medication errors.	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 documented accurately about the completion of health-related care for 1 of 3 discharged tenants reviewed (Tenant C1) and the administration of medication for 1 of 3 current tenants reviewed (Tenant #2). Findings follow: 1. Record review on 7/16/26 of a Monthly task log revealed one employee documented bathing Tenant C1 on 3/17/26. Staff documented they completed safety checks and provided skin care	A 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 276	Continued From page 33	A 276		

to him on 3/16, 3/17, 3/18, 3/19, 3/21, 3/23, 3/28 and 3/29.

Record review on 7/16/26 of observation notes completed by the Health and Wellness Director (HWD) identified Tenant C1's bilateral lower extremities were red and painful on 3/15/26. The HWD encouraged him to go to the Emergency Room for an evaluation. Tenant C1 was admitted and received IV antibiotics for cellulitis in his left foot. There were no discharge plans at that time. He remained in the hospital on 3/16/25. The HWD documented Tenant C1 was transferred to a different hospital on 3/24/26 and continued to receive IV antibiotics for cellulitis. He returned to the Program on 3/30/26.

Tenant C1 was in the hospital on 3/16/26 through 3/29/26 and staff would not have been able to provide bathing or skin care to him on these dates.

2. Observations on 7/22/26 at 1:50 PM. Tenant #2 was scheduled to receive her 2:00 PM dose of Ipratropium/Sol Albuter, inhale 1 vial via nebulizer every six hours. Staff D reported she was unable to administer this treatment as Tenant #2 did not have a nebulizer. Staff D noticed the tenant had an ongoing cough. Tenant #2 confirmed there was an issue with the pharmacy keeping her from getting the nebulizer but she did not know what it was. Tenant #2 experienced a coughing episode as we left the apartment.

Review of a Medication Administration Record (MAR) for July, 2026 revealed Tenant #2 was prescribed Ipratropium/Sol Albuter, inhale 1 vial via nebulizer every six hours on 7/7/26. This medication was added to the MAR on 7/9/26. Most staff documented the medication was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 276	Continued From page 34 administered as it was not available and there was no nebulizer machine to administer the medication. However, staff documented they did administer the medication on the following dates/times: - 7/9/26 at 8:00 PM - 7/11/26 at 8:00 AM and 8:00 PM - 7/12/26 at 2:00 AM and 8:00 PM - 7/16/26 at 8:00 AM and 8:00 PM - 7/18/26 at 8:00 AM - 7/21/26 at 8:00 PM During an exit meeting on 7/23/26 at 10:50 AM the team confirmed the Program failed to ensure staff provided accurate documentation on tenant records.	A 276		
A 282	481-69.26(3) 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to update the service plan of 2 of 3 discharged tenants (Tenant C1 and Tenant C3) and 2 of 5 current tenants (Tenant #2 and Tenant #5) with a significant change. Findings follow:	A 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 282	Continued From page 35 1. Record review on 7/16/26 of a Service plan dated 1/9/26 revealed Tenant C1 was totally dependent on staff to administer and order his medication. He required diabetes management. Staff were to check his blood sugar and give him insulin injections two times per day. Tenant C1 received moderate nursing services as the Health and Wellness Director (HWD) ordered supplies, scheduled appointments and coordinated with his physician and outside providers such as his wound provider. He required skin care provided by licensed and unlicensed staff who were delegated by the nurse. Staff should refer to the Medication Administration Record (MAR) for specifics. He had a mild orientation issue that did not interfere with functioning in familiar surroundings. Tenant C1 could have some short-term memory issues. He received safety checks once per shift. Record review on 7/16/26 of a progress note indicated Tenant C1's bilateral lower extremities were red and painful on 3/15/26. The HWD encouraged him to go to the Emergency Room (ER). His wife took him there. A review of hospital records revealed Tenant C1 went to the ER on 3/15/26 due to concerns for cellulitis of his lower extremity. He reported for the prior two to three days he experienced erythema and swelling of the left lower extremity and was starting to notice some redness in the right lower extremity as well. It was very tender to the touch. He had a history of Type II diabetes, peripheral neuropathy, obstructive sleep apnea, atrial fibrillation, hyperlipidemia and hypertension and amputation of the right fifth toe. He was predominantly wheelchair bound with a history of uncontrolled diabetes and recurrent lower extremity infection.	A 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 282	Continued From page 36	A 282		

During his hospitalization Tenant C1 experienced severe anxiety and agitation, MRSA positive lower extremity cellulitis and sepsis with leukocytosis. Tenant C1 developed Acute hypoxic respiratory failure secondary to daptomycin toxicity. His family noted he was displaying some signs of dementia. He was provided IV steroids and would taper off Prednisone upon his return to the Program. Tenant C1 was on high-dose short acting insulin along with Lantus. The Prednisone could induce hyperglycemia (high blood sugar) but this would improve with the Prednisone taper. He did not adhere to the recommended low carbohydrate diet as his family brought in high carbohydrate snacks and drinks. Tenant C1 was discharged with orders to check his blood sugar four times daily (before meals and at bedtime). His insulin should be held if his blood sugar was less than 120 or if he did not eat a meal, otherwise administered three times a day. Tenant C1's needs were not reassessed by the HWD following this hospitalization.

A continued review of the April MAR revealed instructions for staff to inject 50 units of Humulin (insulin) 3 times daily before meals. There were no instructions about holding the insulin if his blood sugar was low or if he did not eat a meal.

In a review of a Wound Clinic note dated 4/6/26, Tenant C1's wife shared she may have caused a wound to his scrotum by using tape there. He was using a doughnut cushion for offloading. He had been incontinent of bowel recently which was causing pain to his buttocks and scrotum. Since returning home his arms and legs were swollen and he didn't feel well.

Treatment orders from the 4/6/26 Wound Clinic note included: apply a thin layer of TheraHoney to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 282	Continued From page 37	A 282		

buttock wounds daily and as needed. Apply Prisma to the right lower leg wound and cover with Mepilex border. Change dressing every two to three days. Continue wearing Tubigrip to bilateral lower legs. Reposition frequently throughout the day to relieve pressure. Sitting on the donut pillow was not recommended and he should switch to a ROHO cushion. Tenant C1 was edematous and his oxygen level was 94. He agreed to go to the ER. Tenant C1 presented at the ER on 4/6/26. He was assessed and his symptoms were determined to be related to his chronic medical conditions. He should follow up with his primary care provider (PCP) if his symptoms continued.

Record review on 7/16/26 of progress notes indicated Tenant C1 received insulin the night of 4/7/26. Staff documented he refused the 8:00 AM dose of insulin (and all of his morning medications) at 1:34 PM on 4/8/26. The HWD documented in the progress notes on 4/8/26 at 11:03 AM the Med Technician reported Tenant C1 missed his morning medication as he was sleeping in his apartment. The Med Technician indicated she raised her voice to try and wake him up but he wouldn't wake up. The HWD instructed the Med Technician to check his blood sugar and it was 24 (very low). The HWD administered 1 ml of IM Glucagon and called EMS. He was transported to the ER. The HWD called the ER and learned he would be admitted for altered mental status, hypoglycemia and urinary tract infection.

Record review on 8/7/26 revealed the Emergency Documentation noted Tenant C1 arrived at the ER on 4/8/26 at 11:50 AM. Upon arrival he was moaning with his eyes opened but not following commands or providing meaningful

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 282	Continued From page 38	A 282		

communication. His wife arrived at 12:30 PM and reported they went out to eat the previous evening and she took him back to the Program. He seemed normal. Tenant C1 continued to display agitation in the ER, yelling at staff and striking his wife. He was transferred to another hospital.

A review of progress notes on 7/16/26 revealed the HWD went to the hospital on 4/20/26 to assess Tenant C1 for return to the Program. She determined he required a minimum of a 2 person assist. He had a significant cognitive decline, did not respond to much and was frequently unable to take his medication. He was discharged from the Program. Tenant C1 discharged from the hospital on 5/1/26 to a higher level of care.

The Program failed to update Tenant C1's service plan after he returned from the hospital on 3/30/26 where he displayed signs of dementia, agitation, anxiety. He needed his blood sugar checked four times a day and insulin administered three times a day. The clinician at the wound clinic encouraged Tenant C1 to reposition, not use a doughnut and to use a ROHO cushion. No interventions were added. The plan was not updated to include symptoms for staff to be alert for including cellulitis, hyperglycemia and hypoglycemia.

2. Record review on 7/16/26 revealed observation notes for Tenant C3 indicated the following:

- His bilateral lower extremities were red and warm to the touch from his ankle to mid-calf on 3/20/26. The inner lower left extremities had fluid-filled blisters. The Health and Wellness Director (HWD) encouraged him to go for an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

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A 282	Continued From page 39	A 282		

evaluation but he refused. She notified his wife and Primary Care Provider (PCP).
- The HWD assessed his bilateral lower legs on 3/27/26. There was minimal redness but his edema continued. She washed his legs with soap and water and applied wraps.
- He experienced a fall on 4/7/26 at 6:50 PM and found him on the ground in front of his toilet. Tenant C3 continued to experience pain in his lower back and bilateral lower extremities on 4/9. The HWD contacted the PCP to ask for medication to address the pain.
- Tenant C3 was not completing tasks for himself due to lower back pain on 4/10/26. He reported discomfort of 5 out of 10 when walking on 4/13/26.
- He had a red, warm open area on the left lower extremity on 5/26/26. Staff were to cleanse it daily, apply telfa to the open lesions and wrap with kerlix.

Record review on 7/16/26 of a Change of Condition Health Assessment was completed on 3/5/26. It noted Tenant C3 was not experiencing pain. His skin condition was normal other than experiencing dry skin to his upper and lower extremities. Tenant C3 had a service plan dated 3/5/26. It noted staff would assist with his dry, flaky skin as needed. He was known to have ecchymosis and edema. Tenant C3 would maintain his independence with mobility.

Tenant C3's service plan was not updated when he experienced redness, blistering or lesions on his lower extremities requiring wraps or wound treatment. The service plan was not reviewed when he experienced pain which required staff to assist him with his activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 282	Continued From page 40	A 282		

3. Record review on 7/20/26 revealed Tenant #2's 90-day assessment indicated she had one fall with no injuries. She had a scaly rash to her bilateral lower extremities. She asked to discontinue her morphine which would be titrated down until it could be safely discontinued.

Continued record review revealed Tenant #2's observation notes indicated the following:

- She was observed with a harsh, productive cough with yellow mucus on 3/31/26. She was assessed and wheezing was discovered in her bilateral lung fields. An antibiotic was prescribed for seven days.
- She completed her antibiotic on 4/7/26 but a harsh, productive cough continued. She continued to take an expectorant and albuterol inhaler as needed. Tenant #2 was refusing physical therapy and occupational therapy.
- Staff noted Tenant #2 was shaking and slurring her words on 4/18/26. She had an elevated blood pressure. She went to the emergency room.
- The HWD requested a new order for Morphine and Hydrocodone for Tenant #2.
- The PCP ordered a new antibiotic for Tenant #2 on 5/5/26.
- The PCP wrote a new order for physical therapy and occupational therapy due to impaired mobility, history of falls and chronic pain.
- Tenant #2 met with her PCP on 6/8/26 and discussed her chronic cough. A new order was written for a chest x-ray.
- The physical therapist notified staff she had two falls the previous night which she did not report to staff. Staff educated her to use the pendant.
- She reported dryness and cracking skin to the bilateral bottoms of her feet on 6/22/26 as well as coughing and back pain. New orders were received for aquaphor, Biofreeze and tessalon

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 282	Continued From page 41	A 282		

perles.
- Tenant #2 reported a fall. Staff noted empty beer cans in the trash cans. She verbalized understanding mixing medication with alcohol was not advisable.

During an interview on 7/20/26 at 1:20 PM Staff A reported Tenant #2 reported intense levels of pain in order to get her PRN pain medication every four hours. Tenant #2 would lay in bed drinking beer and it seemed to her as if she was addicted to her medication.

When interviewed on 7/15/26 at 3:02 PM Staff C reported Tenant #2 would ask for pain medication every four hours on the dot. Sometimes Staff C would question if Tenant #2 needed the medication and wouldn't rush to provide it. Tenant #2 was getting cases of beer delivered to the building. Staff C noticed the tenant's feet were dry and cracking so they got an order for her to have lotion applied to her feet.

Record review on 7/20/26 of a Comprehensive Assessment, written on 11/17/25 noted Tenant #2 had not experienced any falls in the previous 90 days. She liked to have an occasional glass of wine. A service plan was written on 11/22/25. It noted she had minimal substance use issues. She had a current or history of substance use which may cause some interpersonal and/or health problems but did not significantly impair overall independent functioning. Provider discussed with Tenant #2 she recommended not drinking while on narcotic medication. She was independent with mobility. She could get a rash on her bilateral extremities randomly but would put a cream on her legs independently.

The Program did not update Tenant #2's service

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 282	Continued From page 42	A 282		

plan when her substance use increased from an occasional glass of wine to more frequent cases of beer and potential need for staff interventions. Tenant #2 went off and on physical therapy and occupational therapy. The service plan did not address her respiratory issues, falls or need for assistance with skin care.

4. Record review on 7/22/26 revealed a 90-day Assessment dated 4/4/26 indicated Tenant #5 continued to live independently. She took her medication independently. Tenant #5 had not experienced any falls or injuries. She joined peers at all meals. There was no need for referrals to outside providers. The service plan remained appropriate to meet her needs.

When interviewed on 7/20/26 at 1:20 PM Staff A described the condition of Tenant #5's room as a biohazard. She was known to urinate on her clothing and then hang the soiled clothing up. Her carpet needed deep cleaning. Tenant #5 was very independent so staff were only in her apartment to take out her trash and collect her laundry.

During an interview on 7/21/26 at 8:05 AM Staff J reported when she entered Tenant #5's apartment it was very dirty and had a strong odor. The clothing on her floor was soiled with urine.

When interviewed on 7/21/26 at 12:10 PM Staff K explained she was able to smell urine coming from Tenant #5's apartment when walking down the hall. She was not sure if the tenant needed more assistance with cares as the tenant was very reserved. Staff K could not visibly see signs of Tenant #5's incontinence but could smell the odor when she was in her presence.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 282	Continued From page 43 When interviewed on 7/21/26 at 10:30 AM Staff D stated Tenant #5's apartment was stinky. The tenant would leave her soiled clothing sitting in her bathroom. Staff D would encourage her co-workers to wash Tenant #5's clothing twice to try and rid them of the smell of urine. When Tenant #5 came to meals she would smell of urine. When walking through the building on 7/15/26, 7/16/26, 7/21/26 and 7/23/26 a smell of urine was present in the vicinity of Tenant #5's apartment. During a tour of the building on 7/21/26 at 9:05 AM the Executive Director confirmed she was aware of the odor on that date. Tenant #5 had a service plan dated 1/5/26. It noted she was independent with toileting but had a history of urinary tract infections and used a urinary pad. Tenant #5 received routine housekeeping and laundry services. The service plan was not updated to address possible interventions related to Tenant #5's urinary incontinence. During an interview on 7/23/26 at 10:05 AM the Regional Director of Clinical Operations reported she was not aware of Tenant #5's incontinence. An exit meeting was held on 7/23/26 at 10:50 and the team confirmed the Program failed to update service plans when tenants experienced a change of condition.	A 282		
A 289	481-69.26(4)e Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized	A 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 289	Continued From page 44 and indicate: e. Preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure a preference was listed for nursing facility care on the Individual Service Plans reviewed for 4 of 5 tenants (Tenant #1, Tenant #3, Tenant #4 and Tenant #5). Findings follow: Record review on 7/21/26 revealed the following: 1. Tenant #1's Individual Service Plan dated 5/14/26. Language on the plan included, staff to be aware the tenant has a preference for a nursing care facility if need presents during the assisted living program occupancy. No preference was listed. 2.Tenant #3's Individual Service Plans dated 4/16/26 and 5/19/26. Language on the plans included, staff to be aware the tenant has a preference for a nursing care facility if need presents during the assisted living program occupancy. No preference was listed on either plan. 3.Tenant #4's Individual Service Plan dated 7/17/26 identified she had a very mild cognitive decline, age associated memory impairment. The plan noted she had no nursing home preference.	A 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 289	Continued From page 45 4.Tenant #5's Individual Service Plan dated 1/5/26 noted she had no cognitive impairment. The person filling out the section on nursing home preference was prompted to fill in information as to the facility name, address and phone number. No information was provided. During an interview on 7/23/26 at 8:20 AM with Tenant #4 and Tenant #5 In the dining room, they denied being asked about a nursing home preference when speaking with a nurse about a nursing home preference. Tenant #4 stated she would like to move to River Hills nursing home if she were unable to remain at the Program. Tenant #5 indicated if she was asked, she probably would not have had a nursing home preference. An exit meeting was held with the Regional Director of Clinical Operations on 7/23/26 at 10:50 AM. She met with Tenant #4 on 7/17/26 and verified the tenant did not have a nursing home preference at the time. The Regional Director of Clinical Operations was not working at the Program at the time the other service plans were written and could not speak to why the nursing home preferences were not listed.	A 289		
A 291	481-69.27(2)a Nurse Review 481-69.27(231C) Nurse review. 69.27(2) If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: a. To monitor, at least every 90 days, or after a	A 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 291	Continued From page 46 significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to monitor 3 of 5 tenant's conditions every 90 days to ensure their needs were met (Tenant #1, Tenant #2 and Tenant #4). Findings follow: Record review revealed the following: 1. Tenant #1 had a service plan written 1/9/26. The Program did not review her condition until 4/13/26, which was more than 90 days. 2.Tenant #2 had a 90-day assessment completed on 2/17/26. Her condition was not reviewed after this date. 3.Tenant #4 had a 90-day assessment completed on 12/23/25. Her condition was not reviewed until 7/17/26. During an exit meeting held on 7/23/26 at 10:50 AM the Regional Director of Clinical Operations, the Corporate Director of Operations and the Executive Director confirmed the Program failed to complete nurse reviews every 90 days.	A 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 318	Continued From page 47	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 all food served was held at safe temperatures, potentially affecting all tenants. Findings follow: Observations on 7/16/26 at 11:40 AM on the secured memory care unit served (chicken Alfredo, biscuit, watermelon/cucumber bowl) and there were two plates of food sitting on a dining room table ready for tenants to arrive. Tenant #8 arrived in the dining room at 11:53 AM and sat at a table where a plate of food was sitting for at least 13 minutes. She commented loudly about the chicken Alfredo being cold. Tenant #9 was at the table at 11:40 AM but had not eaten much of her food. She reported it was also cold. Continued observation revealed Staff H checked the temperature of the chicken Alfredo when the food arrived on a warming cart and documented it on a Daily Temp. Log. The chicken Alfredo was 105 degrees, biscuit 48.3 degrees and watermelon/cucumber 57.0 degrees. When Staff H checked the temperature at 11:53 AM the temperature of the chicken Alfredo was 97 degrees. The warming cart was not plugged in. Staff H believed the cart had been broken for a while but did plug it in.	A 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 318	Continued From page 48	A 318		

During an interview on 7/16/26 at 12:10 PM with the Culinary Director, Executive Director and Regional Director of Clinical Operations,the Culinary Director reported the warming cart was broken and should not be plugged in. She'd submitted an order for the cart to be repaired. Her plan to ensure tenants received warm food was for the cart to be taken to the memory care unit after all tenants are seated.

Observations on 7/20/26 at 4:30 PM on the memory care unit, a dining services employee brought the warming cart to the unit. One tenant arrived in the dining room at 4:32 PM. Staff I did not think they had been able to plug the cart in for about a month due to safety concerns. At 5:00 PM, five tenants were in the dining room. The Director of Clinical Operations took the food temperatures. The spring salad with ham was 58 degrees, salad dressings measured 48-52 degrees and fruit was 44 degrees. The Director of Clinical Operations and Executive Director explained they thought the warming cart was fixed ensuring food temperatures were kept at acceptable levels.

A review of selected Daily Temp Logs from 6/1/26 - 7/20/26 revealed the following temperatures in degrees Fahrenheit:

6/1/26: bacon - 88.5, tomato soup - 105.2, grilled cheese - 104
6/9/26: pork tenderloin sandwich - 97.8, tater tot - 101.2, cold sandwich - 71.9
6/21/26: sausage patty - 123.8, bacon - 113.9, diced pork - 101.3, broccoli and carrot mix - 99.1, potato wedges - 109.2, ravioli - 122.4, fruit cocktail - 69.9
7/15/26: cottage cheese - 42, butterscotch pudding - 60, cheese - 69.4, tomatoes - 53.2,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 318	Continued From page 49 eggs - 64.7, carrots - 55.7, lettuce - 46.7, onions - 61.9 7/17/26: salad bar - eggs 42, grapes - 49.1, watermelon salad - 45.9, cottage cheese - 46.8, shredded cheese - 57.8, peppers - 50.3, carrots - 51.2, lettuce - 50 7/18/26: yogurt - 57.9, mandarin oranges - 51.8 During an interview on 7/21/26 at 8:05 AM the Executive Director reported the warming cart was repaired. She confirmed the Program failed to maintain acceptable food temperatures. The Culinary Director had dining staff review and sign a set of work expectations between 7/17/26 and 7/21/26 which included temperature logs being completed every shift.	A 318		
A 330	481-69.30(1) Dementia-Specific Education 481-69.30(231C) Dementia-specific education for program personnel. 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure 6 of 6 staff reviewed who were hired in 2026 received 8 hours of dementia-specific training within the first 30 days of employment (Staff A, Staff C, Staff D, Staff E, Staff F and Staff G). Findings follow: Record review on 7/15/26 revealed Staff A (hired 2/26/26) had not completed dementia-specific	A 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 330	Continued From page 50	A 330		

training, as required. Documentation confirming the completion of this training was absent from the employee's file.

The Program failed to provide dementia-specific training for Staff C. A review of personnel records showed Staff C, who was hired on 1/5/26, did not receive this required training.

The Program failed to provide dementia-specific training for Staff D. A review of personnel records showed Staff D, who was hired on 5/18/26, did not receive this required training.

The Program failed to provide dementia-specific training for Staff E. A review of personnel records showed Staff E, who was hired on 5/19/26, did not receive this required training.

The Program failed to provide dementia-specific training for Staff F. A review of personnel records showed Staff F, who was hired on 5/21/26, did not receive this required training.

The Program failed to provide dementia-specific training for Staff G. A review of personnel records showed Staff G, who was hired on 4/13/26, did not receive this required training.

When interviewed on 7/16/26 at 7:30 AM the Regional Director of Clinical Operations confirmed the Program failed to provide staff with the required 8 hours of dementia-specific training within 30 days of hire.