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FORM APPROVED

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
	S0367	A. BUILDING: _____ B. WING _____	09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES FOR MEMORY	1831 EAST KANESVILLE BLVD COUNCIL BLUFFS, IA 51503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 0 Tenants with cognitive impairment: 36 Total census: 36 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia.	A 000	Please see attached. See attached POC 12/21/26	
A 116	481-67.2(2) Program Policies and Procedures 67.2(2) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to follow established policies. This pertained to 2 of 4 tenants reviewed (Tenant #2 and Tenant #4) and potentially affectrd all tenants residing at the Program. Findings follow: 1. Record review on 9/1/26 revealed Tenant #4 admitted to the program 6/9/26. Tenant #4 had a Global Deterioration Scale (GDS) score of 5 (moderately severe cognitive decline). An incident report dated 8/30/26 indicated Tenant #4 attempted to enter an unlocked program bus parked in the secured courtyard, with no staff present, and fell to his hands and knees. The incident report noted the incident had been	A 116		

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A 116	Continued From page 1 determined after observing the program's courtyard camera footage. Record review on 9/2/26 revealed a Change of Condition Evaluation for Tenant #4 dated 7/17/26. The "Wandering" section of the evaluation identified Tenant #4 "likes to walk/wander within the community but does not attempt to leave or go outside alone." An unsigned service plan for Tenant #4 with a print date of 9/2/26 failed to identify Tenant #4's wandering behavior. Review of the program's established "Wandering or Walk About" policy, dated 8/14/25, directed the following regarding tenants' service plans : a. If the resident wandered frequently or had a history of wandering, interventions would be addressed in the resident's Service Plan, which may include: i. Amount of supervision required, based on availability of alarmed exits, WanderGaurd, or delayed egress. ii. Access to safe space/areas for wandering, including outdoor areas. iii. Redirection techniques iv. Encouraging routine physical activity v. Engaging the resident in preferred activities vi. Use of ambulatory devices vii.Diet and hydration During an interview on 9/3/26 at 9:40am, the Health and Wellness Director (HWD) confirmed Tenant #4's service plan failed to include wandering behaviors or needs as determined by the 7/17/26 change of condition evaluation. She stated she was unsure why the evaluation had not pulled over the information on wandering, but stated the former nurse informed her a lot of things changed after updates were made to the	A 116		

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A 116	Continued From page 2 program's electronic health records system. 2. Record review on 9/1/26 revealed Tenant #2, admitted to the program 3/12/26, had a GDS score of 5 (moderately severe cognitive decline). An incident report dated 8/21/26 indicated Staff B transported Tenant #2 to a dental appointment and Tenant #2 experienced a fall as she exited the program vehicle and began walking towards her spouse. Additional record review on 9/2/26 revealed the program's policy "Transportation & Use of Company Vehicles" (dated 1/27/25) noted the community offered transportation services as part of its commitment to help residents live independently, while maintaining their safety. The policy noted prior to driving a vehicle, the following must occur and all drivers must complete Transportation Safety Training, which included the Transportation Competency Assessment. During an interview on 9/2/26 at 4:50pm the Executive Director (ED) confirmed the program's transportation training included three courses on the Relias educational platform, and then completion of the Training Competency Assessment checklist. The ED stated Staff B had a Training Competency Assessment on file, but she believed Staff B had never had the three Relias courses assigned to him. She contacted corporate support and Staff B now had the three courses assigned to complete. Further record review on 9/3/26 revealed Staff B's original transportation training competency assessment, dated 1/9/25, revealed Performance Criteria included compeltion of three safety	A 116		

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A 116	Continued From page 3 courses via Relias, Provide Safe Transportation, Safe Driving: Large Passenger, and Defensive Driving. A handwritten note next to the section noted "were never assigned." Further review of training documentation noted Staff B completed the three newly assigned courses on 9/2/26. The ED assessed and completed a new Competency Assessment form for Staff B dated 9/3/26. 3. Observations on 9/3/26 at 9:45am revealed a door to the courtyard slightly ajar. At the base of the door, a rock had been placed on the ground to prevent the door from closing. Additional observation at 10:00am revealed the courtyard door remained slightly ajar. Record review on 9/3/26 at 10:00am revealed the program's policy, "Secured-Area and Resident Response Systems", dated 7/31/26. The policy indicated residents, families, and associates relied on secured doors, gates, alarms. It further noted an unrecognized failure could undermine both safety and trust. The policy went on to directed Associates may not prop open, disable, bypass, silence, or improvise around required security or resident response systems. During an interview on 9/3/26 at 10:20am the Executive Director (ED) and Health and Wellness Director (HWD), were unaware the courtyard door had been propped open and confirmed it should not have been. At 10:40am, the ED stated she couldn't provide an explanation for why the courtyard door had been propped open. She stated program doors alert on staff phones, and the expectation would be a staff member would have to accept the task of the door being opened, should then go investigate the door, and then acknowledge the issue/concern had been	A 116		

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A 116	Continued From page 4 resolved. When interviewed on 9/3/26 at 11:48am Staff B stated he observed the courtyard door propped open with a rock in the past and stated he constantly told staff not to do so.	A 116		
A 142	481-67.2 Medications 481-67.5(231B,231C,231D) Medications. 67.5(2) Each program shall follow its own written medication policy, including the following: This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the program failed to follow established medication policies regarding medication handling for 1 of 4 tenants reviewed during medication administration pass observations (Tenant #5). Findings follow: Observations on 9/2/26 at 11:40am revealed Staff A accidentally dropped one capsule of Fluoxetine during the medication administration for Tenant #5. Staff A picked up the capsule from the floor with her bare hands.When asked if another capsule could be used for Tenant #5, Staff A responded she had found the capsule, showed the surveyor the capsule, and then administered the capsule to Tenant #5. Review on 9/2/26 at 12:55pm revealed: a. The Health and Wellness Director (HWD) completed the skills delegation training record for Staff A on 8/31/26, which included Medication Assistance and Administration.	A 142		

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A 142	Continued From page 5 b. The program's Medication Handling policy, dated 9/25/25, directed if a medication spilled, not the amount or dosage spilled on the MAR (medication administration record.) staff should contact the pharmacy for a replacement medication if necessary. The policy further directed, if a medication was contaminated (such as being dropped, getting wet, etc.) staff should note the contamination on the MAR, then use the next available dose or contact the pharmacy for a replacement medication if necessary. When interviewed on 9/2/26 at 4:25pm he Health and Wellness Director (HWD) stated if a medication fell on the floor, the expectation of the staff passing the medication was to ask if the tenant still wanted the pill or wanted to get a replacement pill, but acknowledged the procedural steps of the program's Medication Handling policy.	A 142		
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 interview and record review, the program failed to ensure service plans were signed by all parties for 1 of 1 tenants reviewed	A 282		

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A 282	Continued From page 6 (Tenant #4). Findings follow: Record review on 9/1/26 and 9/2/26 revealed Tenant #4 admitted to the program on 6/9/26. The program completed a change of condition evaluation for Tenant #4 on 7/17/26. No service plan was provided by the program signed by all parties related to the change of condition date. The program provided a service plan with a print date of 9/2/26, which lacked signatures from all parties. Continued record review on 9/2/26 revealed the program's service plans policy, dated 9/25/25, directed the Health & Wellness Director (HWD) should ensure the service plan was signed and dated by the community representative and/or responsible party as appropriate. The policy further noted a signed copy of the service plan should be kept in the resident's record. When interviewed on 9/2/26 at 2:40pm, the HWD stated the program's electronic health records system did not pull over family signatures from the evaluations to the service plans. The HWD confirmed the program was in process of sending out service plans for family representative signatures and acknowledged the service plan for Tenant #4 was not signed by all parties.	A 282		
A 285	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and indicate: a. The tenant's identified needs and preferences for assistance;	A 285		

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A 285	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure service plans were individualized and accurately addressed needs for 1 of 4 tenants reviewed (Tenant #2). Findings follow: Record review on 9/1/26 and 9/2/26 revealed Tenant #2 admitted to the program on 3/12/26. An entrance form provided by the program identified Tenant #2 received hospice services. Review of the current service plan on file provided by the program dated 3/12/26, failed to identify the need for hospice services, a hospice provider, or what services the hospice provider provided. Record review on 9/3/26 of the Hospice Service Agreement for Tenant #2 revealed the hospice start of care date was 8/31/26. When interviewed on 9/2/26 at 4:25pm the Health and Wellness Director stated the program recently met with the family of Tenant #2 and identified the need for hospice services. Tenant #2 selected a hospice provider, but she had not yet updated Tenant #2's service plan as she had not received orders from the hospice provider. She stated she would call and request them and then ensure Tenant #2's service plan was updated.	A 285		
A 288	481-69.26(4)d Service Plans 481-69.26(231C) Service plans. 69.26(4)The service plan shall be individualized	A 288		

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A 288	Continued From page 8 and indicate: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure service plans were individualized and included a list of person-centered planned and spontaneous activities based on the tenant's ability and personal interests or preferences for 4 of 4 tenants reviewed (Tenants #1, #2, #3, and #4). Findings follow: Record review on 9/2/26 and 9/3/26 revealed: 1) Tenant #1 admitted to the program 12/22/25 had a Global Deterioration Scale score (GDS) of 5 (moderately severe cognitive decline). An unsigned service plan with a print date of 9/2/26 revealed the Activities section noted Tenant #1 "independently attends and participates with activities." The service plan failed to include a list of person-centered planned and spontaneous activities based on Tenant #1's ability and personal interests or preferences. 2) Tenant #2 admitted to the program 3/12/26 had a GDS score of 5 (moderately severe cognitive decline). A service plan for Tenant #2 with a print date of 9/2/26 failed to include an Activities section and failed to include a list of person-centered planned and spontaneous activities based on Tenant #2's ability and personal interests or preferences.	A 288		

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A 288	Continued From page 9 3) Tenant #3 admitted to the program 5/12/25 had a GDS score of 4 (moderate cognitive decline). An unsigned service plan with a print date of 9/2/26 revealed the Activities section noted Tenant #3 "independently attends and participates with activities." The service plan failed to include a list of person-centered planned and spontaneous activities based on Tenant #3's ability and personal interests or preferences. 4) Tenant #4 admitted to the program 6/9/26 had a GDS score of 5 (moderately severe cognitive decline). An unsigned service plan for Tenant #4 with a print date of 9/2/26 failed to include an Activities section and failed to include a list of person-centered planned and spontaneous activities based on Tenant #4's ability and personal interests or preferences. When interviewed on 9/2/26 at 2:15pm the Life Enrichment Coordinator (LEC) stated she did not participate in the activity section of the service plan process and was unaware of the regulation requiring service plans to include a list of person-centered planned and spontaneous activities based on tenant abilities and personal interests or preferences. When interviewed on 9/2/26 at 4:25pm the Health and Wellness Director (HWD) acknowledged each tenant's service plan reviewed failed to include a list of person-centered planned and spontaneous activities based on each tenant's abilities and personal interests or preferences and stated she was unaware of the regulation, but would review service plans and work to correct the concern.	A 288		

Agemark SENIOR LIVING

PLAN OF CORRECTION (POC)

Community Name: Country House Council Bluffs Date :10/8/2026

SECTION / TAG	VIOLATION	APPEAL?		PLAN OF CORRECTION	COMPLETED?
A 116 481-67.2	481-67.2(2) Program Policies and Procedures 67.2(2) The program shall follow the policies and procedures established by the program.	☐ YES X NO	What Has Been Done to Correct?	We reviewed our policies and procedures with all staff on September 23, 2026. We reviewed resident wandering risks and updated service plans to reflect individualized supervision and safety interventions. We implemented a transportation return procedure requiring the driver to notify the community so staff can assist residents safely from the vehicle. We reinforced that secured courtyard doors must never be propped open and that door alerts require prompt investigation and resolution.	☐ YES ☐ NO
			How Will Recurrence Be Prevented?	We will document secured-door checks once daily for the next four weeks, and weekly for an additional month. We will review wandering interventions during admission, 30 day, and change-of-condition service plan reviews. The Executive Director or designee will review findings, correct deficiencies promptly, and document follow-up.	
			Person Responsible:	Executive Director or Designee	
			Due Date:	December 14, 2026	

481-67.5(231B,231C,231D) Medications.	67.5(2) Each program shall follow its own written medication policy, including the following:	☐ YES X NO	What Has Been Done to Correct?	We reviewed medication handling policies with our medication aides and completed medication skills review and re-delegation as applicable. We reinforced that a medication dropped on the floor is contaminated and must not be administered. Staff must document the event and obtain an uncontaminated replacement dose in accordance with our medication policy. We will confirm and document individualized reeducation and competency validation for the staff member involved.	☐ YES ☐ NO
			How Will Recurrence Be Prevented?	Our Health and Wellness Director will conduct and document random medication-pass observations across all three shifts weekly for four weeks, followed by random monthly observations for three months. Observations will include proper handling and documentation of dropped or contaminated medications. Any concerns will result in immediate corrective action, staff reeducation, and follow-up competency verification.	
			Person Responsible:	Health and Wellness Director	
			Due Date:	December 21, 2026	
A 282 481-69.26(3) Service Plan	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	☐ YES ☐ NO	What Has Been Done to Correct?	We reviewed resident service plans for individualized needs and required signatures. We will obtain any outstanding signatures or digital signatures from residents or legal representatives and retain signed copies in the residents EHR.	☐ YES ☐ NO

	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		How Will Recurrence Be Prevented?	We will review service plans and signature status at admission, 30 days, and change of condition. The Health and Wellness Director or designee will review signature tracking, document outreach for missing signatures, and follow up until all required signatures are received. We will conduct monthly signature audits for three months and address any gaps identified.	
			Person Responsible:	Executive Director, Health and Wellness Director or Designee	
			Due Date:	December 21, 2026	
SECTION / TAG	**VIOLATION**	**APPEAL?**		**PLAN OF CORRECTION**	**COMPLETE?**
A 285 481-69.26(4)a Service Plans	69.26(4) The service plan shall be individualized and indicate: a. The tenant's identified needs and preferences for assistance;	☐ YES X NO	What Has Been Done to Correct?	We reviewed resident service plans for accuracy and individualization. We will ensure that Tenant #2's plan identifies hospice involvement, the hospice provider, services furnished, and the responsibilities of our staff and the hospice team. We will also review the plans of other residents receiving outside clinical services and update them as needed.	☐ YES ☐ NO
			How Will Recurrence Be Prevented?	We will update service plans whenever a resident begins, changes, or discontinues hospice or other outside services. The Health and Wellness Director will review coordination of services during changes of condition and audit applicable service plans monthly for three months, documenting corrections and follow-up.	
			Person Responsible:	Health and Wellness Director	
			Due Date:	December 21, 2026	

A 288 481-69.26(4)d Service Plans	69.26(4)The service plan shall be individualized and indicate: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests	☐ YES X NO	What Has Been Done to Correct?	We will review every resident's service plan to identify individualized planned and spontaneous activities based on abilities, interests, and preferences. Our Life Enrichment Coordinator will gather input from residents and families and work with the Health and Wellness Director to document specific activity approaches.	☐ YES ☐ NO
			How Will Recurrence Be Prevented?	Our Life Enrichment Coordinator and Health and Wellness Director will review activity preferences at admission and when abilities or preferences change. We will audit activity sections weekly for four weeks and monthly for two additional months to confirm that plans contain individualized planned and spontaneous activities. We will document findings, make corrections, and provide staff education as needed.	
			Person Responsible:	Health and Wellness Director or Life Enrichment Coordinator	
			Due Date:	January 11, 2027	