

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0368	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/14/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

STORYPOINT SIENA HILLS

**455 SW ANKENY ROAD
ANKENY, IA 50021**

(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: 24 Tenants with cognitive impairment: 22 Total census: 46 The following regulatory insufficiencies were cited during the investigation of Complaints #131995-C, #132473-C, and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia. No regulatory insufficiencies were cited during the investigation of Complaint #131241-C or Complaint #132508-C.	A 000		
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 observation, interview, and record review, the program failed to follow established policies related to the policy entitled medication administration for 1 of 4 tenants reviewed during med pass observations (Tenant #6), medication errors for 1 of 7 tenants reviewed (Tenant #3), and incident reporting for 1 of 7 tenants reviewed (Tenant #2). Findings follow: 1. Observation on 7/7/26 at 3:25pm revealed	A 116		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 116	Continued From page 1 Staff A began medication pass for Tenant #6. Staff A held a sealed envelope in her hand and stated it was Tenant #6's Tramadol. Staff A stated another staff member had popped out the medication and left it for Staff A to administer. The surveyor asked to see the medication room and the narcotic count/sign-out binder. Staff A stated the book was locked up. Upon arriving to Tenant #6's apartment, Staff A began to sort through Tenant #6's other medications and dispensed medications into a medication cup, including the reported Tramadol medication from the sealed envelope. The surveyor stopped the medication process and questioned where the Medication Administration Record (MAR) was so Staff A could compare medication package labeling with Tenant #6's prescribed orders. Staff A stated she forgot her laptop, locked up the medications, and then left the apartment to gather her laptop. Staff A returned to the apartment to then compare Tenant #6's orders with the medication package labeling. Staff A administered the medications to Tenant #6, including the reported Tramadol from the sealed envelope. A review on 7/14/26 of narcotic count/sign-off sheets for Tenant #6 revealed Staff C signed out Tenant #6's Tramadol dose on 7/7/26 at 1600 (4:00pm), despite Staff A having initiated the afternoon medication pass at 3:25pm on 7/7/26. When interviewed on 7/14/26 at 10:00am Staff B stated two staff signatures routinely meant the count during shift change, while one staff signature meant the staff who signed out and administered the medication. Review on 7/14/26 of the program's Medication Administration policy (last reviewed/update date	A 116		

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A 116	Continued From page 2 4/11/22), noted, "The person who prepares the dose for administration is the person who administers the dose." When interviewed on 7/14/26 at 10:02am the Wellness Director confirmed the policy and stated "If you pop it (the medication), you should give it. That's what I always tell them (the staff)." The Wellness Director noted Staff A should have disposed of the Tramadol dose in the sealed envelope and prepared her own. 2) When interviewed on 7/7/26 at 2:02pm Staff B stated she recalled a medication error occurred for Tenant #3 involving the tenant's Novolog insulin and Lantus insulin, but couldn't remember which staff had been involved. She believed the medication error occurred within the last two months. A review of the program's last three months of incident reports noted no incident report or medication error report for Tenant #3 involving insulin. When interviewed on 7/7/26 at 2:55pm Staff A denied any medication errors for Tenant #3. When asked to provide a medication error report for Tenant #3 related to insulin, the Wellness Director replied on 7/7/26 via email response at 3:21pm, "No medication error report has been completed." The Wellness Director stated the Staff A notified the nurse on call right after the incident, on call did not initiate the error report, and no paper incident report form was completed. A review on 7/9/26 of Tenant #3's June 2026 MAR revealed a charting code of "9" entered on the date of 6/12/26, indicating per the MAR key code "other/see nursing notes", entered by Staff A.	A 116		

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A 116	Continued From page 3 When interviewed on 7/9/26 at 11:45am the Executive Director (ED) acknowledged the medication error occurred, and stated Tenant #3 called her and reported she was administered the wrong insulin and wanted a staff member stay with her to monitor her per her doctor's request. The ED informed Tenant #3 the program couldn't monitor that. She stated the program offered to either check on Tenant #3 every 30 minutes or offered to send Tenant #3 to the emergency room. She also offered to have her sit in the memory care for closer monitoring, but Tenant #3 didn't want to do that. Tenant #3 opted for every 30-minute checks. When interviewed on 7/9/26 at 2:30pm Tenant #3 recalled being administered the incorrect insulin on 6/12/26. Tenant #3 stated she slept when Staff A entered her room and asked if she was ready for her insulin. She stated she was ready and Staff A went and got the insulin. Tenant #3 stated she wasn't watching the color of the label on the insulin pen at the time of the injection, but then looked down after the injection and noticed it was the incorrect color. Tenant #3 stated she immediately became concerned and questioned Staff A if she had just been administered her fast-acting insulin. She stated Staff A looked down, realized the error of the incorrect insulin, and immediately began apologizing. Tenant #3 stated she called her own "diabetic doctor", who requested program staff stay with her to monitor. Staff A stated she couldn't do that, but offered to take Tenant #3 to memory care for increased monitoring. Tenant #3 stated she didn't want to do this due to her oxygen usage and wanting to toilet in her own room. Tenant #3 stated her endocrinologist was upset. Tenant #3 stated she checked her own blood sugar levels every 30 minutes, but program staff did check in on her	A 116		

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A 116	Continued From page 4 every 30 minutes. During a second interview with Staff A on 7/13/26 at 12:57pm, Staff A acknowledged she administered Tenant #3's insulin on 6/12/26. She stated she had the MAR with her, retrieved an insulin pen from the refrigerator and had verified the pen with Tenant #3. When questioned how the error happened if Staff A had the MAR and had compared the MAR with the insulin pen, Staff A stated "when you have two different pens/insulin, accident happen." Staff A stated she "fixed it, located it, and then checked on" Tenant #3. She stated she noted in the progress notes what her blood sugars were every 30 minutes and insisted Tenant #3 was "perfectly fine in my care." When questioned if she had completed a medication error report, Staff A stated "I called my nurse and ED and followed what their protocol was." When questioned again if she had completed a medication error report, Staff A again stated "I called my nurse and ED and followed what their protocol was." Review on 7/13/26 of the program's provided Medication Error policy (last review/update date 9/26/23) indicated a medication error was defined as a failure to follow the healthcare prescriber's instructions when administering a prescription medication, including: Administration of the wrong medication and Administration of the wrong dose of medication. The policy directed a medication error report form shall be completed. Record review on 7/14/26 of a progress note dated 6/12/26 for Tenant #3 noted the order for Tenant #3's Lantus "inject 30 units subcutaneously two times a day", but noted Tenant #3 had instead been administered 30 units of Tenant #3's Novolog insulin.	A 116		

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A 116	Continued From page 5 When interviewed on 7/13/26 at 1:12pm the Wellness Director stated everybody had the ability to make an error. Tenant #3 had called her endocrinologist. She believed Tenant #3's physician requested she go to the ER, but Tenant #3 refused, and Staff A was advised to monitor Tenant #3's blood sugars every 30 minutes. The Wellness Director stated the program offered for Tenant #3 to go to the memory care for further visual monitoring, but Tenant #3 declined, and the program provided Tenant #3 with ample sugar. The Wellness Director confirmed again no medication error report had been completed. The Wellness Director stated it would be standard practice for a medication error report to be completed, and was per the program's policy. The Wellness Director stated it would have been the responsibility of the person making the error, in this case, Staff A to complete the medication error report. 3) Record review on 7/8/26 of incident reports revealed the following four incident reports related to Tenant #2: *5.25.26 - witnessed fall. The report noted Tenant #2's physician was notified of the incident, but not Tenant #2's representative. *6.29.26 - witnessed fall. The report noted Tenant #2's physician was notified of the incident, but not Tenant #2's representative. *7.1.26 - fall/suspected fall. The report noted Tenant #2's physician was notified of the incident, but not Tenant #2's representative. *7.4.26 - fall/suspected fall. The report noted Tenant #2's physician was notified of the incident, but not Tenant #2's representative. Record review on 7/8/26 revealed Tenant #3's occupancy agreement dated 4/24/25 identified	A 116		

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A 116	Continued From page 6 the daughter of Tenant #3 as the tenant's responsible party and legal representative. The occupancy agreement further stated "If a Resident has designated a "Responsible Party" the Resident must also authorize the Community to provide information regarding the Resident and their residency at the Community, including health information..." Additional record review on 7/8/26 revealed the program's incident reporting policy (implementation 3/19/25) directed the resident's representative and health care provider would be notified, if applicable. Record review on 7/9/26 revealed Tenant #3 signed an Authorization to Release and/or Obtain Information form, dated 5/11/26, with all areas of information marked "x", and included Tenant #3 authorized "the release of any and all information requested by (Tenant #3's representative)", identified Tenant #3's acting representative, and included "please honor my request to release information to (Tenant #3's) representative." When interviewed 7/9/26 at 11:45am the ED acknowledged the incident reports and stated Tenant #3 was his own representative. When questioned about Tenant #3 having signed on release on 5/11/26, prior to the incident reports in question, the ED provided no further explanation on why the program failed to notify Tenant #3's representative of the incidents. On 7/14/26 at 11:30am, the Executive Director and Wellness Director confirmed the above findings regarding Tenant #6, Tenant #3, and Tenant #2.	A 116			

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A 152	Continued From page 7	A 152		
A 152	481-67.5(2)e(3) Medications 481-67.5(231B,231C,231D) Medications. 67.5(2)?Each program shall follow its own written medication policy, including the following: e. When medications are administered traditionally by the program: (3) Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or PA. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to properly administer medications as prescribed by the tenant's physician for 3 of 3 tenants reviewed (Tenant #2, Tenant #5, and Tenant #3) Findings follow: 1) Record review on 7/9/26 of an incident progress note for Tenant #2 dated as a late entry on 2/6/26 noted "RN was notified by the Resident Care Coordinator that resident was administered x2 doses of Memantine 10mg on: 1/31/26 at 1902, 2/2/26 at 1935, and 2/3/26 at 1913." A review of Tenant #2's orders as indicated on the January 2026 Medication Administration Record (MAR) and February 2026 MAR revealed Tenant #2's treating physician had prescribed Memantine, 10mg tablet and instructed program staff to administer 1 tablet by mouth at bedtime. This was scheduled on the MAR for a time of 2000. When interviewed on 7/9/26 at 11:45am the	A 152		

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A 152	Continued From page 8 Executive Director acknowledged the medication error occurred. The ED stated she believed involved an order which wasn't correctly discontinued. She stated the program had a temporary nurse who had realized an order hadn't been discontinued and the program was in process of transferring nurses. 2) Record review on 7/7/26 of an incident report for Tenant #5 dated 5/23/26 revealed a medication error and noted, "Nurse alerted resident's AM Quetiapine tab 25mg was given twice on 5/23/26 AM Dose." A review of Tenant #5's May 2026 MAR revealed two entries for Quetiapine. Tenant #5's treating physician had prescribed Quetiapine, 25mg tablet, and instructed program staff to administer 1 tablet by mouth twice daily, hold dose if sedated, with an order start date of 5/15/26 and a discontinue (D/C) date of 5/22/26. Tenant #5's treating physician had then prescribed Quetiapine, 25mg tablet, and instructed program staff to administer 1 tablet by mouth three times a day with an order start date of 5/22/26. When interviewed on 7/9/26 at 11:45am the ED acknowledged the medication error occurred. She stated she didn't know, but thought it involved a duplicate order in the system. 3) During a staff interview on 7/7/26 at 2:02pm, Staff B stated she recalled a medication error occurred for Tenant #3 involving the tenant's Novolog insulin and Lantus insulin. She couldn't remember which staff had been involved, but believed the medication error occurred within the last two months. A review of the program's last three months of incident reports noted no incident report or	A 152		

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A 152	Continued From page 9 medication error report for Tenant #3 involving insulin. During a staff interview on 7/7/26 at 2:55pm, Staff A denied any medication errors for Tenant #3. When asked to provide a medication error report for Tenant #3 related to insulin, the Wellness Director replied on 7/7/26 via email response at 3:21pm, "No medication error report has been completed." The Wellness Director stated the Staff A notified the nurse on call right after the incident, on call did not initiate the error report, and no paper incident report form was completed. A review on 7/9/26 of Tenant #3's June 2026 MAR revealed a charting code of "9" entered on the date of 6/12/26, indicating per the MAR key code "other/see nursing notes", entered by Staff A. When interviewed on 7/9/26 at 11:45am the ED acknowledged the medication error occurred, and stated Tenant #3 called her and reported she was administered the wrong insulin. During an interview with Tenant #3 on 7/9/26 at 2:30pm, Tenant #3 recalled being administered the incorrect insulin on 6/12/26. Tenant #3 stated she had been sleeping when Staff A entered her room and asked if she was ready for her insulin. Tenant #3 recalled she stated she was ready and Staff A went and got the insulin. Tenant #3 stated she wasn't watching the color of the label on the insulin pen at the time of the injection, but then looked down after the injection and noticed it was the incorrect color. Tenant #3 stated she immediately became concerned and questioned Staff A if she had just been administered her fast-acting insulin. She stated Staff A looked	A 152			

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A 152	Continued From page 10 down, realized the error of the incorrect insulin, and immediately began apologizing. During a second interview with Staff A on 7/13/26 at 12:57pm, Staff A acknowledged she administered Tenant #3's insulin on 6/12/26. She stated she had the MAR with her and stated she had retrieved an insulin pen from the refrigerator and had verified the pen with Tenant #3. When questioned how the error happened if Staff A had the MAR and compared the MAR with the insulin pen, Staff A stated "when you have two different pens/insulin, accident happen." Staff A stated she "fixed it, located it, and then checked on" Tenant #3. She stated she noted in the progress notes what her blood sugars were every 30 minutes and insisted Tenant #3 was "perfectly fine in my care." When questioned if she had completed a medication error report, Staff A stated "I called my nurse and ED and followed what their protocol was." When questioned again if she had completed a medication error report, Staff A again stated "I called my nurse and ED and followed what their protocol was." On 7/14/26 at 11:30am, the Executive Director and Wellness Director confirmed the above findings.	A 152		
A 191	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by:	A 191		

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A 191	Continued From page 11 Based on interview and record review, the program failed to provide a sufficient number of trained staff to fully meet tenants' identified needs for 1 of 12 tenants reviewed (Tenant #2) with the potential to affect all tenants residing at the program. Findings follow: Record review on 7/8/26 revealed a staff communication note dated 7/6/26, authored by Staff D, described an incident on 7/5/26 where a police officer arrived at the program after receiving a 911 call indicating Tenant #2 needed assistance. The staff communication note revealed Staff D escorted the police officer to Tenant #2's apartment, where Tenant #2 stated he was having an anxiety attack. He reported he pushed his call light and had not seen or heard anyone. He became scared it was the end of the world and everyone was gone except him. Tenant #2 stated he used his urinal because no one came. The staff communication note then described Staff A then assisted Tenant #2 to the restroom. When interviewed on 7/13/26 at 11:30am the responding officer stated he had been dispatched at 8:08am. Upon arriving at the program and being taken to Tenant #2's room he found Tenant #2 sitting in his recliner. Tenant #2 stated he pushed his call light around 6:47am, but couldn't get a hold of the nurses, It had been over an hour and he needed to use the restroom. The officer noted the tenant had a full urinal sitting by him. The officer stated Tenant #2 noted staff usually came in at 7:00am, but no one had come so he called 911. The officer stated Tenant #2 had no visible soiling or injuries. The officer stated Staff A arrived to the room within 1-2 minutes and stated she was the only one working that day. She noted around the time Tenant #2's pendant/call light had	A 191		

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A 191	Continued From page 12 gone off, seven other tenants' call lights had gone off as well and she was assisting others. During an interview on 7/7/26 at 2:02pm Staff B stated it depended on the day if there was enough staff to completed all assigned tasks/cares each shift. Staff B felt 2nd shift was pretty understaffed currently, especially on the weekends. The Program scheduled one staff member for the assisted living and one staff member in each of the two memory care halls/units. When interviewed on 7/7/26 at 2:24pm Staff E stated "it's healthcare, sometimes quality of staff is better than quantity of staff." During a follow-up interview on 7/9/26 at 10:30am, Staff E stated the program expected staff to respond to tenant call lights within 15 minutes. If staff were in with another resident, they could send a message to another co-worker, front desk, Executive Director, one of the other bosses with access to it, so all were aware a tenant needed something. When interviewed on 7/9/26 at 2:20pm Staff F reported the Program needed more staff on the weekends. She further noted Staff were expected to respond to tenants' call lights within five minutes and reported that was the limit. During an interview on 7/9/26 at 2:25pm Staff G stated staffing could be rough, especially on the weekends or if tenants needed showers. Staff G stated there were three staff regularly on a shift, but the program didn't always have three staff available. She reported staff were always expected to respond to tenants' call lights for assistance within five minutes During an interview on 7/9/26 at 2:30pm Tenant	A 191		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

STORYPOINT SIENA HILLS

**455 SW ANKENY ROAD
ANKENY, IA 50021**

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A 191	Continued From page 13 #3 reported overall staffing levels at the program were "lousy" and felt the average staff response time was 40 minutes. During an interview on 7/13/26 at 3:20pm Tenant #8 reported there were not enough staff. Tenant #8 stated sometimes she pushed her call light for assistance and waited almost an hour for someone to come. She stated a lot of the staff reported only one staff available on the night shift, not including memory care. She felt the program was "very short-staffed." When questioned about the length of time her call light went unanswered on the morning of 7/5/26, Tenant #8 couldn't recall specifics or which staff had been working, but stated "that could be right" regarding the response time. She stated unanswered call lights happened several times and it had got to the point where she would write down the time she called for assistance and then check again when staff eventually responded. Record review on 7/13/26 revealed three staff scheduled on day shift on 7/5/26. Review of the call light device activity report from 7/5/26 from 6:30am to 8:15am revealed the following: - Tenant #2 called for assistance at 6:46:59am, with the call light answered/cleared after 104 minutes, 21 seconds - Tenant #3 called for assistance at 6:47:09, with the call light answered/cleared after 54 minutes, 49 seconds - Tenant #9 called for assistance at 6:59:11am, with the call light answered/cleared after 17 minutes, 7 seconds - Tenant #10 called for assistance at 7:16:37am, with the call light answered/cleared after 19 minutes, 20 seconds - Tenant #11 called for assistance at 7:26:39am,	A 191		

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A 191	Continued From page 14 with the call light answered/cleared after 125 minutes, 57 seconds - Tenant #8 called for assistance at 7:30:43am, with the call light answered/cleared after 109 minutes, 9 seconds - Tenant #12 called for assistance at 8:12:30am, with the call light answered/cleared after 63 minutes, 33 seconds Further record review on 7/8/26 revealed call light device activity reports for Tenant #2 from 2/13/26 to 7/8/26 included call light response times over 30 minutes on at least the following occasions: - 3 occasions in February - 3 occasions in March - 9 occasions in April - 10 occasions in May - 11 occasions in June - 4 occasions in July Record review on 7/8/26 revealed Tenant #2's Occupancy Agreement and included Tenant Handbook noted, "The Community shall employ sufficiently trained staff to be available to meet identified resident needs." When interviewed on 7/13/26 at 12:57pm Staff A stated she was responsible for scheduling of the direct care staff. Staff A stated the program didn't have staff, and most recently struggled with staffing during a time of changeover of two management companies within 90 days. Staff A stated she felt both management companies had "failed" her, as she had two applicants who waited over a month before the management company allowed her to hire, and she almost lost the two applicants. Staff A reported the program preferred to have call lights answered within 15 minutes or less, but circumstances happen. Staff A confirmed the schedule on 7/5/26 and noted	A 191		

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A 191	Continued From page 15 she worked the floor on the assisted living portion of the program, while an additional staff worked the memory care halls/units. Staff A stated she was manager/supervisor for the shift and governed the meds, schedule, narcs, and everything else. Upon arriving to the program for the shift, Staff A prepared the narcotics needed and passed meds, got people up, dressed, toileted, beds made. She reported the med pass usually took her 2-3 hours to complete. Staff A stated she received a text on the work phone alerting her Tenant #2 called the police. She walked down to Tenant #2's apartment and law enforcement was there with the cook. Staff A stated Tenant #2 usually called 2-3 times on the overnight shift and it took about 40 minutes to get ready in the morning. Staff A stated Tenant #2 usually didn't get up until 8-8:30am, but sometimes at 5:30am he would alert the overnight staff to help him get up and get dressed and sit in his chair. Staff A did not provide an answer as to whether she had observed or provided any cares to Tenant #2 prior to Tenant #2's call to 911. When questioned if it was a normal morning, Staff A stated it was; call lights went off like normal, only she had just herself instead of two staff working the floor to answer them. When interviewed on 7/13/26 at 1:12pm the Wellness Director reported she was not responsible for staffing. She stated she felt like there was never enough staff in healthcare. Everyone wanted to be a 1:1, and that just wasn't possible. The Wellness Director stated in the past, Staff A requested temporary agency staffing, but the request was denied by the management company. Program leadership had also asked for approval for bonuses for staffing, but the request had been declined. The Wellness	A 191		

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A 191	Continued From page 16 Director felt Staff A had done everything in her power to try and get workers in. She stated Staff A worked 1-2 shifts per week on the floor, whether it was half or full shifts. The Wellness Director acknowledged staffing was an issue every other weekend, but the program had three new hires which would be scheduled on the weekend in question. When interviewed on 7/9/26 at 11:45am the program's Executive Director (ED) stated the program didn't have a set time staff were required to respond to call lights within, but they expected staff to answer call lights promptly. The ED stated sometimes a staff member may be in with another tenant, and the program expected them to get to the call light as soon as possible.	A 191		
A 251	481-69.24(1)b Involuntary Transfer 481-69.24(231C) Involuntary transfer from the program. 69.24(1)Program initiation of transfer. The program shall comply with Iowa Code section 231C.6 and the following: b. The program will immediately provide to the office of long-term care ombudsman, by mail or email, a copy of the notification and notify the tenant's treating physician, if any. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to notify the tenant's treating physician of notice of involuntary discharge for 1	A 251		

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A 251	Continued From page 17 of 1 pending discharged tenants reviewed (Tenant #2). Findings follow: Record review on 7/7/26 revealed Tenant #2 admitted to the program on 4/24/25. Tenant #2 was served a 30-day notice of involuntary discharge dated 7/2/26. The notice included notification (cc) of Tenant #2's family representative and the local long-term care ombudsman, but did not include notification of the treating physician for Tenant #2. When interviewed on 7/9/26 at 11:45am the Executive Director confirmed she did not notify the tenant's treating physician. She believed the Program verbally informed the physician. When interviewed on 7/14/26 at 11:30am, the Wellness Director stated she believed she had verbally left a message about the involuntary discharge with the nurse of the treating physician for Tenant #2 the same date she had requested a urinary analysis (UA) order for Tenant #2. Record review of a progress note for Tenant #2 dated 7/2/26 noted a call was placed to the treating physician's office requesting an order for a UA per family request and a message was left for the nurse, and indicated the program was waiting on a return call or new order. The program was unable to produce documentation Tenant #2's treating physician was notified of Tenant #2's pending involuntary discharge. When interviewed on 7/13/26 at 3:55pm Tenant #2's Primary Care Provider reported she learned of Tenant #2's notice of involuntary discharge from the family representative of Tenant #2 on 7/2/26. She confirmed she had not been notified of the notice of involuntary discharge by/from the program.	A 251		

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A 288	481-69.26(4)d Service Plans 481-69.26(231C) 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; 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 2 of 3 memory care tenants reviewed (Tenant #4 and Tenant #7). Findings follow: Record review on 7/13/26 revealed the following: 1 Tenant #4 admitted to the program 6/8/26. Review of a Resident Listing Report revealed Tenant #4 resided in the memory care unit and had a Global Deterioration Scale (GDS) score of 4, indicating moderate cognitive decline. Tenant #4's initial service plan signed/dated 6/4/26 revealed the Life Enrichment section noted Tenant #4 required assistance in activities. Tenant #4's 30-day service plan signed/dated 7/6/26 #4 revealed the Life Enrichment section noted , "Resident will require assistance with tasks related to life enrichment." Both service plans failed to include a list of person-centered planned and spontaneous activities based on	A 288		

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A 288	Continued From page 19 Tenant #4's ability and personal interests or preferences. 2 Tenant #7 admitted to the program 5/23/23. Review of a Resident Listing Report revealed Tenant #7 resided in the memory care unit and had a GDS score of 4, indicating moderate cognitive decline. Tenant #7's service plan dated 7/17/25 with revision last signed/dated by Tenant #7's representative on 8/8/26 revealed the Life Enrichment section noted Tenant #7 independent in activities of interest. The service plan 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 7/13/26 at 1:12pm the Wellness Director confirmed the verbiage of the Life Enrichment sections of the service plans for Tenant #4 and Tenant #7. When interviewed on 7/14/26 at 8:40am the Life Enrichment Director confirmed the verbiage of the Life Enrichment section of the service plans for Tenant #4 and Tenant #7. The Life Enrichment Director stated she did not write the service plans, but usually would have a discussion with the Wellness Director with suggestions for wording on the Life Enrichment section. She stated Tenant #4 stuck more to himself in memory care and was more of a 1:1 for activities, had hospice come in for music therapy, and participated in the activities of sensory bins or fidget bins. She stated Tenant #7 was more social, liked bingo, happy hour, and was not really into activities offered in memory care, but preferred to come out to the assisted living side and participate with activities. The Life Enrichment Director stated she guessed they missed adding tenant's preferred activities to the	A 288		

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A 288	Continued From page 20 service plan.	A 288			