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
	S0375	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE ALPD	3 RUSSELL SLADE BLVD CORALVILLE, IA 52241

(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: 5 Tenants with cognitive impairment: 25 Total census: 30 The following regulatory insufficiencies were cited during the investigation of Complaints #131335-C, #131810-C, #131921-C, #131972-C and Incident #132075-I:	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 interview and record review the Program failed to follow established policies and procedures, which pertained to 7 of 9 current tenant files reviewed (Tenants #2, #3, #4, #5, #6, #8 and #9) current tenants reviewed and 2 of 2 discharged tenants (Tenant C1 and Tenant C2) and potentially affected all tenants (census of 30). Findings follow: 1. Record review on 5/27/26 revealed the Program's Advance Medical Directive policy, dated 2/01/22, indicated at the time of move in the Program would inform the tenant or legal representative in writing of the statutes related to advance medical directives. An advance directive acknowledgement form would be completed. Upon move in, the tenant would be asked to provide any health care related advance	A 116		

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A 116	Continued From page 1 directives that had been executed. If there was an advance directive in effect, the program would keep a copy in the clinical record. Upon move in, a Do Not Resuscitate (DNR) order would be discussed. If there was a DNR in place it would be placed in the tenant's file. If a copy was not received of the DNR the Program would document in the file a copy had been requested. If a DNR did not exist and if requested a copy would be provided. Record review on 6/8/26 revealed the following Tenants listed below did not have an advance directive or an advance directive acknowledgement form in their file: a. Tenant #5 b. Tenant #6 c. Tenant #8 d. Tenant #9 When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed the above finding. 2. Record review on 5/26/26 revealed the Program's incident reports policy, dated 8/15/25, indicated an incident was an unusual and unexpected adverse event that had the potential to cause harm or result in harm, injury to death. The supervisor on duty was responsible for handling all incidents. Blood pressure, pulse, respiration and temperature were to be taken for every incident. The shift supervisor completed the incident report (online) within two hours of the incident. Part of the investigation was to interview any caregivers or witnesses. Once the incident report was completed in the online system the nurse and/or director would review it and conduct any follow up to determine the cause.	A 116		

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A 116	Continued From page 2 a. Record review on 6/4/26 revealed Tenant #2's incident report, dated 3/28/26 at 7:34 a.m., indicated staff went into her apartment to give her medications and found that she seemed to roll off of her bed, her head was on the bottom of the nightstand and she complained of her head pain. Blood pressure and pulse were recorded. Oxygen saturation was not reading as she would not keep it on her finger. Staff did not administer her medication and changed her soiled clothes. The report noted "head to toe-stool on shoulder blades-legs to shoulders soaked in urine and stool." The witness name and contact number were not completed. Temperature and respiration rate were not recorded. The report indicated Tenant #2 was admitted to the hospital and then to skilled care. The provider was notified on 3/30/26 and the family on 3/28/26. The date the report was documented as completed was 4/29/26 (over a month after the incident). The person completing the report was the Former Licensed Practical Nurse (LPN). b. Record review on 6/04/26 revealed an Incident Report, dated 2/27/26 indicated Tenant #3 became aggressive toward staff and was choking, pushing, grabbing and yelling. The incident report lacked vitals, the witness name and number and did not identify any corrective measures. c. Record review on 6/8/26 revealed Tenant #9's incident reports, dated 5/29/26, 5/7/26, 5/1/26, 4/25/26, 4/6/26 and 4/1/26 for aggressive acts and falls. Vitals signs were only recorded on the incident report for 4/25/26. None of the other incident reports recorded vital signs. The incident report dated 5/1/26 noted a witness name and contact information completed. The other incident reports failed to have the witness name	A 116		

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A 116	Continued From page 3 or contact information completed. d. Record review on 6/4/26 revealed Tenant C1's incident report dated, 3/26/26 at 12:13 a.m. indicated staff completed a wellness check and found him on the ground with the walker on the bed. Tenant C1 was breathing with eyes closed and responded to verbal prompts. Emergency medical services (EMS) transferred him to the emergency department (ED). The incident report lacked a witness name, contact information and vital signs. e. Record review on 6/4/26 revealed Tenant C2's incident reports dated 3/14/26 (bruising) and 4/23/26 (fall) failed to note vital signs, a witness name and contact information. The 4/23/26 incident report also lacked a nurse and director follow up and signature. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed the above finding. 3. When interviewed on 6/8/26 at approximately 3:00 p.m. to 3:05 p.m. Staff D indicated when she first started at the building a lady (staff) yelled at Tenant #4. She worked with Staff E on second shift. She heard a loud bang and a yell. It was heard again and it led them to Tenant #4's door. Staff F came out of the apartment. Staff F said she scared Tenant #4 and that was why Tenant #4 yelled. Staff D did not think it was that Staff F scared her. After that Staff E reported it to the Former Executive Director. Staff F indicated the door was open but it was closed. It sounded more like Tenant #4 yelled and she did not hear Staff F. Staff D heard other people say Staff F was mean to Tenant #4. Staff D said Staff E had reported it.	A 116		

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A 116	Continued From page 4 When interviewed on 6/9/26 at 4:50 p.m. the Former Executive Director indicated here were no reports of mistreatment or abuse regarding Tenant #4. Attempts were made to contact Staff E; however, were unsuccessful. Attempts were made to contact Staff F; however, were unsuccessful. Record review of Tenant #4's file revealed there was no documentation related to the allegation noted above. Additionally, the Program did not have any documentation of the reported allegations or concerns related to Tenant #4 and Staff F. Record review on 6/15/26 of the Program's policy, Abuse, Neglect and Exploitation Investigation and Reporting, dated 5/09/23, indicated a written record would be maintained of each investigation or reported abuse, neglect or exploitation. The Executive Director ensured the policy and procedure was followed. The investigation included interviewing witnesses and staff and document the occurrence of the interviews. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed there was no documentation related to allegations or concerns regarding Tenant #4. 4. Record review on 6/04/26 revealed the Program's Elopement/Missing Resident policy, dated 2/17/26, indicated Village Program Neighborhoods would conduct daily checks of alarmed doors and locked gates. The check was to confirm that alarmed doors and gates were	A 116		

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A 116	Continued From page 5 activated; and worked correctly. The checks would be completed by a medication technician or nurse during the third shift and documented in the electronic medication administration record (MAR). The daily gate checks would be completed by the medication technician or nurse during the first shift and documented in the electronic MAR. Record review on 6/01/26 revealed there was no documentation of daily door alarm checks provided. When interviewed on 6/3/26 at 2:51 p.m. Staff G indicated the alarms went off all day long. She confirmed there were no scheduled checks and thought maybe maintenance completed the checks. When interviewed on 6/4/26 at 3:19 p.m. Staff H indicated alarms went off all day long, she explained it should be getting checked twice per day if it was getting done. When interviewed on 6/3/26 at 1:40 p.m. the Clinical and Quality Assurance Specialist indicated the checks were not documented. Per the Business Office Manager they were reporting verbally but it was not documented in the electronic record system. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist the door alarm checks were not documented.	A 116		
A 122	481-67.3(2) Tenant Rights 481-67.3(231B,231C,231D) Tenant rights. All tenants have the following rights:	A 122		

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A 122	Continued From page 6 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 care, treatment and services that were adequate and appropriate. This pertained to 3 of 9 current tenants reviewed (Tenants #2, #3 and #7) and 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 6/4/26 revealed Tenant #2's incident report, dated 3/28/26 at 7:34 a.m. indicated staff went into her apartment to give her medications and found her on the floor. She seemed to roll off of her bed, her head was on the bottom of the nightstand and she complained of her head pain. Blood pressure and pulse were recorded. Oxygen saturation was not reading as she would not keep it on her finger. Staff did not administer her medication or change her soiled clothes. It was noted "head to toe-stool on shoulder blades-legs to shoulders soaked in urine and stool." The provider was notified on 3/30/26 and the family on 3/28/26. The date the report was documented as completed was 4/29/26 (over a month after the incident). Further record review revealed Tenant #2's February and March 2026 medication administration records (MARs) reflected an order for albuterol nebulizer 0.083%, use one vial via nebulizer twice daily. The MAR reflected on 3/4/26 new tubing was needed. On 3/19/26, 3/20/26 and 3/24/26 the MAR indicated it was not administered as it was missing a piece or was awaiting a new part.	A 122		

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A 122	Continued From page 7 Continued record review revealed Tenant #2 ' s Observations (nurse's notes) indicated the following: On 3/9/26, Tenant #2 had chest pain and said an elephant was sitting on her chest. She was transferred to the hospital. She returned to the building with no new orders. On 4/10/26, Tenant #2 returned and discharge instructions were verified and sent to the pharmacy. Further record review revealed Tenant #2 ' s hospital records indicated she presented to the emergency department (ED) on 3/28/26 with a fall. She was admitted for acute hypoxic respiratory failure. At 6:45 a.m., she was found on the floor, with a headache and back pain. She did not require oxygen at her baseline and noted to have a new oxygen requirement of four liters (L). The chest commuted tomography (CT) suggested atypical mycobacterial infection. It was likely the cause of the oxygen requirement. Her principal diagnosis was pneumonia due to an infectious organism. When interviewed on 6/9/26 at 12:03 p.m. Staff A indicated she told the nurse Tenant #2's nebulizer was dirty and she could not pull it apart to clean it. She held the treatment and did not get a new one. She also told Tenant #2's private caregiver. There was build up and spots. After each treatment staff were supposed to clean it and soak it in water. When interviewed on 6/8/26 at 3:00 p.m. Staff D explained Tenant #2 was supposed to get a replacement tube and she got a lung infection	A 122		

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because of it. Tenant #2 ' s tubing needed to be replaced and she heard it had mold in it. Staff D indicated she cleaned the nebulizer each time and there was not really a spot for staff to document when it was cleaned.

When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed the nebulizer was expected to be cleaned daily.

2. Record review on 6/4/26 revealed Tenant #3's Observations (nurse's note) dated 2/27/26, indicated Tenant #3 had physical aggression during the overnight. The Former Licensed Practical Nurse (LPN) educated staff on how to keep Tenant #3 engaged when he was not able to sleep. Staff was told not to block Tenant #3's way if he attempted to leave his apartment and walk around the unit.

Continued record review revealed an Incident Report dated 2/27/26 indicated Tenant #3 became aggressive toward staff and was choking, pushing, grabbing and yelling. The incident report lacked vitals, the witness name and number and did not identify any corrective measures.

When interviewed on 6/9/26 at 10:10 a.m. Staff B explained she trained a new staff (Staff C) that night. They tried to keep Tenant #3 occupied in his apartment, tried to show him the television in his apartment. Staff B and Staff C stood in the doorway/close to the doorway to his apartment and Tenant #3 was in the doorway to his apartment. Staff B indicated it was better to occupy him in the apartment and if not, they would bring him out to the living area. She thought the staff was trying to redirect him back to

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his chair. Tenant #3 tried to slam the door and Staff B put her foot on the door. She thought he kicked her foot and put his forearm up to her neck. Staff C stepped in and indicated he could not do that. Then Tenant #3 backed up. Tenant #3 shut the door and went back to wandering on the unit. Staff B explained she had laundry in the room in the back and she preferred Tenant #3 was content in the apartment with redirection first. Tenant #3 was safe in his apartment due to his exit seeking. It was reported to the medication manager and the medication manager talked to the Former Licensed Practical Nurse (LPN). She wrote out a version of events on a piece of paper as she could not complete an incident report. Staff B indicated she did not have access to it in the electronic record system. She reported the Former LPN called the next day and told her to make sure she wrote what happened. The Former LPN told her it was better to have Tenant #3 cool down than to redirect. Staff B said she preferred to have him in the apartment as he was very exit seeking. He had set off door alarms before.

When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist indicated regarding Tenant #3 and what the staff could have done differently, she said laundry could be done later.

3. Record review on 6/8/26 revealed Tenant #7's observation note, dated 4/9/26, indicated Tenant #7's legal representative went to the nurse that morning. Tenant #7 appeared to be lethargic and upset. The legal representative checked the camera overnight to see if he had trouble sleeping. Pictures were provided to the Program from the camera footage at 7:42 p.m. last evening, which showed him beginning to slide

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down the recliner. He continued to slide down without checks from staff until 10:21 p.m. The 8:30 p.m. incontinence check was not completed. The nurse received a call from the caregiver last night at 10:17 p.m. asked how he could be toileted at night. Staff was told he could stand and sit in a wheelchair and be taken to the bathroom and he was to be laid down in bed either on the right side or back. Video footage showed two staff in the apartment at 10:21 p.m. assisting him to the bathroom. At that time he slid all the way down in his recliner and was almost on the floor. The medication manager worked for the staffing agency and it was reported to his supervisor. The other staff (program) was suspended pending investigation of falsifying documentation (8:30 p.m. incontinence check).

Continued record review revealed the Recorded Care Report reflected the following:

a. 4/8/26 at 7:00 p.m. dressing assistance was scheduled. It was signed off as completed at 9:27 p.m.

b. 4/8/26 at 7:00 p.m. oral hygiene was scheduled. It was signed off as completed at 9:27 p.m.

c. 4/8/26 at 7:00 p.m. well-being checks were scheduled. It was signed off as completed at 9:27 p.m.

d. 4/8/26 at 8:00 p.m. garbage removal was scheduled. It was signed off as completed at 9:27 p.m.

e. 4/8/26 at 8:30 p.m. incontinence assistance was scheduled. It was signed off as completed at

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A 122	Continued From page 11 11:36 p.m. The tasks were all signed off as completed by Staff C. Staff C was no longer employed by the program. Attempts were made to interview Staff C; however, were not successful. Further record review revealed Tenant #7 moved in on 4/6/26. On 4/8/26 the above incident occurred. Tenant #7's diagnoses included: Parkinson's disease and dementia. Tenant #7's service plan reflected he required assistance with toileting, dressing, hygiene and mobility. Tenant #7 did not receive services that were adequate and appropriate. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist said regarding Tenant #7 ' s tasks could be signed off like medications, one hour before or after. 4. Record review on 6/4/26 revealed Tenant C1's incident report dated 3/26/26 at 12:13 a.m. indicated staff completed a wellness check and found him on the ground and the walker on the bed. Tenant C1 was breathing with eyes closed and he responded to verbal prompts. Emergency medical services (EMS) was activated and he was transferred to the emergency department (ED). The incident report lacked a witness name and contact information and vital signs. Continued record review on 6/4/26 revealed Tenant C1's Observations (nurse's notes) included: a. 3/27/26, Tenant C1 fell in the early morning on 3/26/26 and was seen in the ED. He was diagnosed with an ulnar fracture and initially a small subdural hematoma. A second scan	A 122		

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completed two hours later showed the fluid decreased and resolved. He returned with new orders to hold Eliquis for seven days and to start Keppra 500 milligram (mg), for 7 days. He returned with a sling to wear for comfort but he kept removing the sling so it was taken off.

b. 3/27/26, staff was informed he fell on Wednesday and a minor brain bleed and fractured elbow. He stood up and was very confused and he was not responding well with verbal cues. Staff assisted him to lay down and he was non-responsive. His blood pressure was 212/152 with a pulse of 54. His pupils were fixed. He was sent to the hospital.

c. 3/28/26, he returned from the hospital at 4:00 a.m.

d. 4/1/26, Tenant C1 appeared off and was not verbally responding. Staff were not able to assist with care due to him not responding. His oxygen was 70%, his pulse was 116 and respirations was 14. He was sent out to the hospital by ambulance.

Further record review revealed the recorded care report entries after Tenant C1 ' s fall reflected the following:

a. Grooming/hygiene scheduled at 7:00 p.m. on 3/25/26 signed off as completed on 3/26/26 at 12:51 a.m.

b. Dressing/physical assistance scheduled at 8:00 p.m. on 3/25/26 signed off as completed on 3/26/26 at 12:51 a.m.

c. Incontinence assistance/bowel/bladder scheduled at 8:00 p.m. and signed off as

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A 122	Continued From page 13 completed on 3/26/26 at 12:51 a.m. d. Oral hygiene/physical assistance scheduled at 8:00 p.m. on 3/25/26 and signed off as completed on 3/26/26 at 12:51 a.m. e. Garbage removal scheduled at 10:15 p.m. on 3/25/26 was completed on 3/26/26 at 12:51 a.m. f. Well-being checks scheduled at 10:30 p.m. on 3/25/26 and signed off as completed on 3/26/26 at 12:51 a.m. Continued record review revealed Tenant C1 ' s hospital records indicated he presented to the ED with a fall. He had an unwitnessed fall that evening. He was anticoagulated on Eliquis. They found him with his walker on the bed and were unsure how he got there. He had an abrasion to the left elbow. The records indicated a small right forehead contusion with "tiny SDH in the right anterior cranial fossa." Also, concern for an acute fracture (elbow). He was given a sling for the elbow fracture, Eliquis was on hold for one week and he was prescribed Keppra for 7 days. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist indicated Tenant C1, tasks could be signed off like medications, one hour before or after.	A 122		
A 152	481-67.5(2)e(3) Medications 481-67.5(231B,231C,231D) Medications. 67.5(2)?Each program shall follow its own written medication policy, including the following: e. When medications are administered	A 152		

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A 152	Continued From page 14 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 observation, interview and record review the Program failed to administer medication as ordered. This pertained to 6 of 9 current tenants reviewed (Tenants #3, #4, #5, #6, #7, #8, #9 and #10), and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow: When interviewed on 6/8/26 at 3:00 p.m. Staff D indicated sometimes refrigerated medications were not being put back into the refrigerator and were in the narcotic box. She indicated at times with new orders the medication was not there when she left. 1. Record review on 6/4/26 revealed Tenant #3's April 2026 medication administration record (MAR) reflected an order for Ketoconazole cream 2%, apply topically to underarms twice daily. It was documented the medication was not available to administer on 4/8/26. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist indicated for Tenant #3's medication was probably put in a different place in the cart. 2. Record review on 6/8/26 revealed Tenant #4's April 2026 MAR reflected the following: a. An order for budesonide suspension 0.5 mg,	A 152		

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inhale contents of one vial nebulizer everyday. It was not administered as ordered on 4/17/26, 4/18/26 and 4/21/26. On 4/17/26 it was noted as other and the machine was not working. On 4/18/26, it was noted as other and not vaporizing when liquid was in it and on 4/21/26 it was noted as other, the nebulizer not working.

b. An order for Denta 5000 cream plus, apply one application to teeth at bedtime. It was documented as medication not available on 4/24/26. It was documented as available and as administered on 4/23/26 and 4/25/26.

c. An order for Johnson's Baby Powder, apply to inguinal folds twice daily after bathing and or/incontinent cares. The treatment was documented as not completed due to medication not available on 4/12/26, 4/15/26, 4/17/26, 4/25/26, 4/26/26 and 4/29/26. It was charted as not administered on 4/25/26 due to staff not being able to find it.

d. An order for povidone-iodine solution 10%. Use betadine 10% topical pad stick, paint skin tear on right leg with betadine twice daily and leave open air. Call hospice if supplies were needed. It was documented as not administered on 4/2/26, 4/9/26 and 4/10/26, medication not available.

When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist had no explanation for Tenant #4's medication issues above. She indicated it was improper charting and was not discontinued after healed.

3. Record review on 6/8/26 revealed Tenant #5's April 2026 MAR, reflected an order for albuterol nebulizer 0.083%, inhale contents of one vial via

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nebulizer every morning. It had a start date of 4/14/26. From 4/15/26 to 4/17/26 it was documented as completed. On 4/18/26 it was charted as medication not available and Tenant #5 did not have a nebulizer. From 4/19/26 to 4/21/26 it was documented as not administered due to no nebulizer equipment. From 4/22/26 to 4/24/26 it was documented as completed. From 4/25/26 to 4/27/26 it was documented as not administered due to no nebulizer equipment.

Continued record review revealed Tenant #5 ' s May 2026 MAR reflected an order for flucti/Salme aerosol, inhale one puff orally, twice daily was not administered due to not being available on 5/21/26 and 5/22/26.

When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist indicated Tenant #5 ' s one medication was a re-order from the pharmacy. Regarding the nebulizer, she wondered if staff signed off at time for the inhaler.

4. Record review on 6/8/26 revealed Tenant #6's April 2026 MAR reflected Diclofenac 1% gel, apply topically 4 gram (GM) three times daily. On 4/20/26, it was not administered due to not being available. It was available the rest of the month to administer. An order was also reflected for triple antibiotic ointment, cleanse third and fourth toe on the right foot and third toe on the left foot with soap and water. Pat dry with clean gauze and apply triple antibiotic ointment. Cover with a band-aid, change daily. It was not documented on 4/20/26 as medication was not available. It was available for the rest of the month to administer (unless refused).

Continued record review revealed Calmoseptine

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ointment applied topically to scrotum and bottom twice daily until healed was not completed as ordered on 5/14/26 due to the medication not being available. The MAR reflected an order for Fluticasone spray 50 microgram (mcg), instill two sprays in each nostril daily. It was not administered on 5/30/26 due to the medication not being available. The MAR also reflected an order for triple antibiotic ointment, cleanse the third and fourth toe on the right foot and third toe on the left foot with soap and water. Pat dry with clean gauze and apply triple antibiotic ointment. Cover with a band-aid, change daily. It was documented as not administered on 5/9/26 and 5/14/26 due to the medication not being available.

When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed Tenant #6's medication not available.

5. Record review on 6/8/26 revealed Tenant #7's order to crush all medications except Levsin. Lactaid Fast Act 9,000 vanilla flavored chewable tablet. Take one tablet with the first bite of lunch and supper scheduled and one Lactaid tablet crushed with the first bite of dairy snacks and breakfast as needed. Crush Lactaid and mix with 5 milliliters (ml) of juice prior to administration.

Observations on 6/4/26 at lunch time, Staff I administered medication to three tenants including Tenant #7. Prior to the start of the mediation pass, there were no water cups or pudding on the medication cart. Staff I went to Tenant #7's apartment and started to prepare his medications. She looked in the cart and could not locate his rosuvastatin 40 mg, take one tablet by mouth every day. She initially marked it as not available and needed to be re-ordered. The Clinical and Quality Assurance Specialist went

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through the medication cart and located the card of the medication. The medication was misfiled. Staff I crushed the rosuvastatin and the Lactaid fast chewable 9000. Staff I crushed both medications and mixed them in chocolate pudding. The Lactaid was administered in Tenant #7's apartment, prior to the meal and was not administered in 5 ml of juice as ordered. Staff I also administered Gentamicin solution 0.3% OP, three drops in both eyes three times daily for three days. During observation it did not appear Tenant #7's eyes were open when the drops were administered.

When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed all MARs and orders requested were provided.

6. Record review on 6/8/26 revealed Tenant #8's April 2026 MAR reflected only as needed (PRN) medications were ordered. Acetaminophen tablet 325 mg, take two tablets by mouth every six hours PRN. It was administered 10 times in May and the outcome or effectiveness of the medication failed to be documented except one time. The MAR also reflected an order for Diclofenac Gel 1%, apply 2 GM to affected area three times daily PRN. It was administered six times and the outcome or effectiveness was documented twice.

Continued record review revealed Tenant #8 ' s May 2026 MAR reflected only as needed medications were ordered. Acetaminophen tablet 325 mg, take two tablets by mouth every six hours PRN. It was administered seven times in May and the outcome or effectiveness of the medication was not documented for any of the times it was administered. The MAR also

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reflected an order for Diclofenac Gel 1%, apply 2 GM to affected area three times daily PRN. It was administered three times and the outcome or effectiveness was documented one time.

When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed all MARs and orders requested were provided.

7. Record review on 6/8/26 revealed Tenant #9's April 2026 MAR reflected an order for Trazodone tablet 100 mg tablet, take half tablet by mouth daily PRN. It was documented as administered eight times. The outcome or effectiveness was not documented four times it was administered.

Continued record review revealed Tenant #9 ' s May 2026 MAR reflected an order for nitrofurantoin macrocrystal oral capsule 100 mg, take one capsule by mouth twice daily for five days. It was documented as not available to administer on 5/30/26 (twice) and 5/31/26 (5:00 p.m. dose). It was documented as administered on 5/31/26 at 8:00 a.m.

Further record review revealed Tenant #9 ' s incident report, dated 6/4/26 indicated Tenant #9 did not receive her Diclofenac gel or her 2:00 p.m. Trazodone related to a clerical error. It was noted the Business Office Manager moved Tenant #9 out of the building in error (in the system) and the assigned medication technician was not able to see scheduled medications for Tenant #9 during the afternoon medication pass. The June 2026 MAR reflected Diclofenac gel 1% apply 4 GM to the low back and right hip four times daily was not administered on 6/4/26 at 12:00 p.m. Additionally, the Trazodone 50 mg tablet, take one tablet by mouth three times daily

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A 152	Continued From page 20 was not administered on 6/4/26 at 2:00 p.m. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist for Tenant #9 she was out at the hospital on 6/1/26. She indicated the eye drops would not be given in the dining room. 8. Observations on 6/4/26 at the lunch time pass Staff I administered medications. Medications were administered to three tenants including Tenant #10. Staff I first donned gloves to prepare to administer eye drops to Tenant #10. After donning the gloves, she touched several contaminated surfaces and was directed by the Clinical and Quality Assurance Specialist (who also observed) to change her gloves as she touched surfaces. Staff I changed her gloves and the eye drop was administered in the common area of the unit. The drops were prednisolone suspension 1% OP, instill one drop in the left eye three times daily for 30 days. Staff I signed off the eye drop on 6/4/26 at 12:00 p.m. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist all MARs and orders requested were provided. 9. Record review on 6/4/26 revealed Tenant C2's May 2026 MARs reflected an order for morphine sulfate solution 100/5 ml, give 0.5 ml by mouth every two hours as needed for pain and shortness of breath (SOB). It was documented as administered 12 times and the outcome/effectiveness was only documented three times. The MAR also reflected an order for lorazepam concentrate 2 mg/ml, give 0.5 ml, every two hours as needed. It was documented as administered 11 times. The outcome and effectiveness was only documented twice. It was	A 152		

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A 152	Continued From page 21 also noted the order did not reflect the reason the as needed medication should be administered. The purpose recorded with doses included restlessness, agitation, anxiety and "prn." The MAR also reflected an order for hyoscyamine tablet 0.125 mg, take one tablet every two hours as needed for terminal secretions. It was documented as administered five times and the outcome/effect was documented one time. It was also noted as not effective. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist all MARs and orders requested were provided.	A 152		
A 191	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide sufficient trained staff available to meet tenants needs. This pertained to 1 of 1 tenant reviewed who eloped (Tenant #1) and potentially affected all tenants (census of 30). Findings follow: 1. Record review on 6/2/26 revealed Tenant #1's Observations (nurse's notes) indicated the following: a. 4/25/26, Tenant #1's family was notified of the elopement and transfer to the hospital.	A 191		

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A 191	Continued From page 22 b. 4/25/26, Tenant #1 returned from the hospital. Continued record review revealed Tenant #1 ' s incident report, dated 4/25/26 indicated she came out of her apartment and appeared to be in a bad mood. She threw her make-up bag at another tenant and picked it up and threw it again. She ran down the hallway and pushed on the tenant's door. After pushing it a few times, the door opened and set off the alarms. She ran to the elevators on the opposite side of the building. Staff lost sight of her when she went onto a different floor. Staff found her on second floor. Staff stood in front of the door so she could not go into the staircase. She started to run but tripped and she fell face first and broke her glasses. Staff got her back to the unit. She was taken to the hospital by paramedics. When interviewed on 6/9/26 at 12:03 p.m. Staff A indicated between 7:00 a.m. to 8:00 a.m., Tenant #1 was in one of her moods. She went to the entrance and pushed on the door and it opened. Tenant #1 ran to the opposite side of the building and ran back to the unit area. It was posted on the group chat to help look for her. The nurse was notified. She was located on second floor and once Staff A went up there she was told Tenant #1 fell and tripped on her blanket. Paramedics were called. The door alarmed and it opened. Staff A indicated it took 5 to 10 minutes (regarding timeframe Tenant #1 was gone). When interviewed on 6/4/26 at 3:19 p.m. Staff H indicated she worked with Staff A and an agency staff. She was getting someone else ready and mentioned you could not hear the alarm well in the apartments. A weird noise did go off on the phones for the door alarm. She heard the alarm	A 191		

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and had to leave one of the tenants on the toilet. Staff H explained Tenant #1 was gone when she came out. The door was still alarming. Staff A went out first and also left a tenant unattended. Staff H went up and down the halls. She checked the AL side and there were several AL staff looking. Staff H sent a text message in the messaging system to let staff know. Staff H said it was about 10 to 15 minutes looking. Tenant #1 had a wreath in her hand, staff blocked the hallway and once all got her into a circle she took off running. She fell and her glasses broke. Staff got her inside the unit and she went to the hospital via ambulance. Regarding the third staff, agency staff, Staff H reported she had no idea what the agency staff was doing and never saw her face until after. The agency staff was still in the unit, not knowing what was going on.

2. When interviewed on 6/926 at 12:03 p.m. Staff A indicated scheduled services for the most part were completed but the tenants' service plans needed updated.

When interviewed on 6/8/26 at 3:00 p.m. Staff D explained maybe sometimes scheduled service was done but not everything. Sometimes tenants were not wearing hearing aides or glasses. There were a lot of problems with hearing aides not getting on the charger. For checks she was not 100% sure rounds were getting done. She indicated third shift was not doing laundry (linens), half to the majority of the time.

When interviewed on 6/4/26 at 3:19 p.m. Staff H indicated tenants were not really receiving scheduled service, but when she worked tenants did. She explained sometimes when she came on shift the tenants were soaked in urine or bowel movement. It was mostly agency staff before

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A 191	Continued From page 24 when it occurred. She indicated upstairs (second floor unit) there were a lot of heavy people and cares were hard to complete. It was appropriate to have the third person on shift. When interviewed on 6/9/26 at 2:01 p.m., a family member indicated their tenant did not get all scheduled care and services because they were short staffed. The family member came in multiple hours per day to provide care to the tenant. The family member said staff called in and agency filled in. The family said they really did not have enough staff. The staff did the best they could and the float called in. It recently occurred and it left two staff. 3. Review of current tenant files Recorded Care Reports (task logs) for Tenants #1, #2, #3, #4, #5, #6, #7, and #9 indicated tasks were not documented as completed at the times scheduled. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Specialist indicated the expectation regarding tasks was that they were charted in live time.	A 191		
A 193	481-67.9(3) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(3) Documentation. The program shall have training records and staffing schedules on file and maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures. This REQUIREMENT is not met as evidenced	A 193		

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A 193	Continued From page 25 by: Based on interview and record review the Program failed to maintain training records. This pertained to 4 of 4 agency staff reviewed (Staff J, K, L and M). Findings follow: Record review on 6/1/26 revealed that invoices for March, April and May 2026 provided by the Program indicated that Staff J, K, L and M (agency staff) worked at the Program in that time period. Record review revealed documentation of training materials for door alarms and dementia education were requested for agency staff (Staff J, K, L and M). Documentation of the training failed ot be provided by the Program. The Program did not ensure staff training was completed and did not maintain a copy of the training. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist indicated she started in-service training and maintenance staff went over door alarms.	A 193		
A 198	481-67.9(4)d 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: d. Direct care staff will receive training regarding service plan tasks in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status.	A 198		

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A 198	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide nurse delegated training for staff. This pertained to 2 of 4 staff reviewed (Staff F and Staff N). Findings follow: 1. Record review on 6/9/26 revealed Staff F's training documents indicated she was hired on 7/2/25 and terminated on 5/3/26. Staff F ' s file failed to provide completed documentation of nurse delegation training. 2. Record review on 6/9/26 revealed Staff N's training documents indicated she was hired on 3/23/26. Staff N ' s file failed to provide completed documentation of nurse delegation training. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed the above finding.	A 198		
A 232	481-69.22(3) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation. This REQUIREMENT is not met as evidenced	A 232		

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A 232	Continued From page 27 by: Based on interview and record review the Program failed to complete evaluations as needed with change in condition. This pertained to 5 of 9 tenant reviewed (Tenants #1, #3, #4, #7 and #8) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Record review on 6/2/26 revealed Tenant #1's Observations (nurse's notes) indicated the following: a. On 4/24/26, Tenant #1 hit another tenant on 4/22/26 when she was agitated. b. On 4/24/26, Tenant #1 threw water on another tenant. c. On 4/25/26, Tenant #1's family was notified of the elopement and transfer to the hospital. d. On 4/25/26, Tenant #1 returned from the hospital. e.On 4/26/26, Tenant #1 woke up that morning and tried to exit the unit. Staff were monitoring closely. g. On 4/27/26, a call was placed to the hospital to see if Tenant #1 had been hospitalized after staff reported family took her out of the building and did not return. She was admitted under observation. She would be most likely discharged that day. h. On 4/30/26, family hired a private caregiver and would be coming in daily 1:00 p.m. to 4:00 p.m. i. On 5/2/26, Tenant #1 tried shaking the chair another tenant was seated in. She opened the doors and staff followed her out. Continued record review revealed Tenant #1 ' s incident report, dated 4/25/26 indicated she came out of her apartment and appeared to be in a bad mood. She threw her make-up bag at another	A 232		

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tenant and picked it up and threw it again. She ran down the hallway and pushed on the door. After pushing it a few times, the door opened and set off the alarms. She ran to the elevators on the opposite side of the building. Staff lost sight of her when she went onto a different floor. Staff found her on the second floor. Staff stood in front of the door so she could not go into the staircase. She started to run but tripped and she fell face first and broke her glasses. Staff got her back to the unit. She was taken to the hospital by paramedics.

Further record review revealed Tenant #1 ' s evaluations, completed on 2/17/26 and then on 5/19/26. Evaluations were not completed as needed with changes noted above or post elopement.

2. Record review on 6/4/26revealed Tenant #3's Observations (nurse's notes) included:

a. On 5/18/26, Tenant #3 seemed more anxious lately. He was whistling more, tried to exit seek, went through things, slept less. He tried to put things in his mouth despite food being offered.
b. On 5/21/26, Tenant #3 chewed his medications.
c On 5/28/26, he was digging things out of the trash can at night, even when the bag was changed. He was whistling and rocking but smiled at staff.
d, On 6/1/26, Tenant #3 was awake most of the night, he went through rooms and had multiple elopement attempts. He showed anxiety all night. He had no medications as needed to help with sleep or anxiety. He experienced those kinds of nights multiple times per week over the past months.

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A 232	Continued From page 29 Continued record review revealed Tenant #3's evaluations were completed on 5/13/26. Evaluations were not completed as needed with changes noted above. 3. Record review on 6/8/26 revealed Tenant #4's Observations (nurse's notes) included: a. On 3/4/26, Tenant #4 was seen by the primary care provider (PCP) and a new order was received for a calorie supplement three times daily. b. On 3/5/26, a referral was received for hospice on 3/4/26 due to decline and weight loss. Hospice would be coming tomorrow for admission. It was noted a change of condition would be completed related to hospice admission. c. On 3/28/26, Tenant #4 was constantly falling asleep at meals. d. On 4/5/26, Tenant #4 was breathing very hard and deep. Her feet were gray white in color and her hands. Oxygen saturation was 86 %. e. On 4/6/26, hospice was there to follow up on the emergency department (ED) visit. A request was sent for albuterol solution nebulizer treatments four times daily. f. On 5/24/26, Tenant #4's oxygen was put on due to her breathing being off and very heavy. She had a hard time walking. When checked her oxygen was 93%. g. On 5/25/26, Tenant #4 had wheezing and she was constantly falling asleep. Continued record review revealed Tenant #4's evaluations were completed on 2/8/26 and 3/6/26. The evaluation on 3/6/26 did not reflect the hospice admission. Evaluations were not completed as needed for an admission to hospice, falling asleep including at meals and	A 232		

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A 232	Continued From page 30 difficulty breathing. 4. Record review on 6/8/26 revealed Tenant #7's Observations (nurse's notes) included: a. On 4/11/26, Tenant #7 asked staff what color bra they were wearing. b. On 5/2/26, Tenant #7 was having difficulties eating dinner, had choked, threw up at dinner and had tremors. There was a lot of rattling in his lungs and the coughing was loud. Family and hospice talked about putting in an order for thickened liquids and using a syringe for water intake as he aspirated on liquids. c. On 5/4/26, new orders were received to change the diet to soft with thickened liquids. d. On 5/22/26, when staff assisted to change him he tried to unzip staff's sweatshirt and look down their shirt. Continued record review revealed Tenant #7 ' s order dated 5/28/26 indicated the diet was soft, bite sized finger foods as tolerated. Food was to be cut into small pieces. Avoid dry, hard crumbly textures, supervision during meals, upright positioning for all intake and to monitor for signs of aspiration. Further record review revealed Tenant #7's evaluations were completed on 4/21/26 and not updated as needed with changes in diet and behaviors as noted above. 5. Record review on 6/8/26 of Tenant #8's file revealed Observations (nurse's notes) included: a. On 4/5/26, Tenant #8 had expressed suicidal thoughts to staff and said things like if staff did not help her get out she was going to break a window and jump and if staff did not let her out	A 232		

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she was going to kill herself. She had also reported hand and back pain.
b. On 4/22/26, Tenant #8 kept saying she wanted to leave, another tenant was bothering her.
c. On 4/24/26, a follow up was completed related to a tenant-to-tenant altercation. The other tenant hit Tenant #8 on the back.
d. On 5/29/26, she was asking to leave and said she did not want to be there.
e, On 6/5/26, Tenant #8 was aggressive towards staff and threatened to kill staff and swung at them.

Continued record review revealed Tenant #8's evaluations were completed on 5/11/26 (90 day review). Evaluations were not completed with suicidal ideations, wanting to leave and behaviors with another tenant.

6. Record review on 6/4/26 of Tenant C1's file revealed Observations (nurse's notes) indicated the following:

a. On 3/27/26, Tenant C1 had a fall in the early morning on 3/26/26 and was seen in the ED. He was diagnosed with an ulnar fracture and initially a small subdural hematoma. A second scan completed two hours later showed the fluid had decreased and resolved. He returned with new orders to hold Eliquis for seven days and to start Keppra 500 milligrams (mg) for 7 days. He returned with sling to wear for comfort but he kept removing the sling so it was taken off.
b. On 3/27/26, staff was informed he had a fall on Wednesday and a minor brain bleed and fractured elbow. He stood up and was very confused and he was not responding well with verbal cues. Staff assisted him to lay down and he was non-responsive. His blood pressure was 212/152 with a pulse of 54. His pupils were fixed.

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A 232	Continued From page 32 He was sent to the hospital. c, On 3/28/26, he returned from the hospital at 4:00 a.m. d. On 4/1/26, Tenant C1 appeared off and was not verbally responding. Staff were not able to assist with cares due to him not responding. His oxygen was 70%, his pulse was 116 and pulse was 14. He was sent out to the hospital by ambulance. Continued record review revealed Tenant C1's evaluations were completed on 3/26/26 but were not updated with changes in responsiveness, increased confusion and changes with cares. Additionally, when the change of condition was completed on 3/26/26 a cognitive evaluation was not completed. 7. Record review on 6/4/26 of Tenant C2's file revealed Observations (nurse's notes) indicated the following: a. On 4/22/26, Tenant C2 had an unwitnessed fall that resulted in a laceration above his right eye and a bloody nose. He was transferred to the ED and returned. He was diagnosed with a bilateral nasal bone fracture and received six sutures to the laceration above the right eye. Orders were received from hospice to hold his Eliquis, start on a soft diet with thickened liquids with a straw. Dietary was notified of the new order. b. On 4/23/26, hospice brought in a wheelchair to help decrease falls and Eliquis was discontinued due to a high fall risk. c. On 4/25/26, Tenant C2 was urinating on both sides of the recliner. d. On 4/28/26, Tenant C2 seemed to be more calm with a 1:1 caregiver. e. On 5/5/26, Tenant C2's temperature was elevated.	A 232		

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A 232	Continued From page 33 f. On 5/6/26, Tenant C2 had a rattle and labored breathing. His feet were swollen and body had signs of stiffening. Morphine was increased to every two hours. g. On 5/7/26, morphine and lorazepam were given throughout the night. Tenant C2's breathing had become more labored. h. On 5/7/26, Tenant C2 was unresponsive at that time and comfort cares were to continue. i. On 5/8/26, Tenant C2 died early that morning. Continued record review revealed Tenant C2's evaluations, completed on 4/13/26; however, were not completed with a change in condition with the fall with nasal fracture and lacerations, a wheelchair, discontinuation of the blood thinner, changes in urination, diet changes, a one to one caregiver, decline and comfort cares. Additionally, when the change of condition was completed on 4/13/26, a cognitive evaluation was not completed. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed the above finding.	A 232		
A 237	481-69.23(1)c(1-2) Criteria for Admission and Retention 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1)?Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention, chronically elopes or is sexually, verbally, or physically aggressive or	A 237		

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A 237	Continued From page 34 abusive; or (2) Displays behavior that places another tenant at risk; or This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to discharge a tenant that exceeded level of care. This pertained to 1 of 9 current tenants reviewed (Tenant #9). Finding follows: 1. Record review on 6/8/26 revealed Tenant #9's Observations (nurse's notes) included: a. On 4/6/26, Tenant #9 refused cares from other caregivers. She was yelling in her apartment. Staff heard her yelling for help and said she did not want to be here anymore. She was in her recliner with the foot rest out, one leg off of the rest and one leg trying to stand up and get out of her chair. Four different staff tried different techniques to calm her down. She became physical and did not want anyone to touch her. She had another yelling episode later and staff administered as needed Trazodone. b. On 4/13/26, Tenant #9 became agitated and combative. It took three staff to assist Tenant #9 so she would not fall. c. On 4/15/26, a care conference was held with family to discuss behaviors and the move to the second floor memory care unit. Tenant #9 had a private caregiver daily. d. On 5/1/26, Tenant #9 came out of the room	A 237		

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agitated and was incontinent of urine. She requested assistance but was not redirectable. She refused to go to the bathroom and change her brief. She became increasingly agitated and started swatting at staff.

e. On 5/1/26, Tenant 9 #had a red rash on both sides of her groin.

f. On 5/1/26, Tenant #9 cried out for help and staff found her sitting on the foot rest of the recliner. Staff assisted to change her and she became increasingly agitated. She became combative. Staff assisted her to bed and she started kicking staff.

g. On 5/2/26, staff went in at 4:00 a.m. to check on tenant as other staff were having issues with her cooperating with tasks. She yelled at staff to get out of her room and to stop touching her. Staff attempted to calm her down by reminding her what was needed to be done. Tenant #9 tried to punching and hitting staff.

h. On 5/2/26, Tenant #9 was very agitated and aggressive. She hit, slapped and shoved staff. She kept saying she was going to bite staff.

i. On 5/8/26, Tenant #9 was very agitated and became combative during evening cares.

j. On 5/11/26, Tenant #9 was incontinent of urine and needed a shower. Tenant #9 kept refusing assistance from staff and was agitated and aggressive.

k. On 5/16/26, Tenant #9 had a rough morning and woke up incontinent of urine. Two staff were needed to change her.

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A 237	Continued From page 36 l. On 5/31/26, Tenant #9 had behaviors while staff were trying to assist her with morning cares. The behaviors included: hitting, threatening to bite, and kicking. When interviewed on 6/9/26 at 12:03 p.m. Staff A indicated in the last week or so she was able to assist Tenant #9 with one. Some mornings she was soiled it took two or three staff. She could get very physical. When interviewed on 6/8/26 at 3:00 p.m. Staff D indicated if she was in a good mood staff could use one person, if not then two or three staff were used. Continued record review revealed incident reports were dated 5/29/26, 5/1/26, 4/6/26 and 4/1/26 for aggressive acts for Tenant #9. Further record review revealed Tenant #9 admitted to the program on 12/30/25 and diagnoses included moderate Alzheimer's dementia. She was staged at a six on the GDS, which indicated severe cognitive decline. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed Tenant #9's move out date was scheduled for 7/10/26.	A 237		
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	A 268		

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A 268	Continued From page 37 delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 2 of 9 current tenants reviewed (Tenant #2 and Tenant #9) and 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 6/4/26 revealed Tenant #2's incident report dated 3/28/26 at 7:34 a.m., indicated staff went into her apartment to give her medications and found she seemed to roll off of her bed, her head was on the bottom of the nightstand and she complained of her head pain. Blood pressure and pulse were recorded. Oxygen saturation was not reading as she would not keep it on her finger. Staff did not administer her medication and changed her soiled clothes. It was noted "head to toe-stool on shoulder blades-legs to shoulders soaked in urine and stool." Continued record review revealed Observations (nurse's notes) included: a. On 3/9/26, Tenant #2 had chest pain and said an elephant was sitting on her chest. She was transferred to the hospital. She returned to the building with no new orders. b. On 4/10/26, Tenant #2 returned and discharge	A 268		

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A 268	Continued From page 38 instructions were verified and sent to the pharmacy. Further record review revealed the evaluation completed 4/9/26 indicated she was admitted to the hospital and then went to rehabilitation before returning to the Program. Continued record review revealed a nurses' note was not completed when Tenant #2 went out to the hospital on 3/28/26 or the rehabilitation stay prior to her return on 4/10/26. 2. Record review on 6/8/26 revealed Tenant #9's Observations (nurse's notes) included: a. On 5/28/26, Tenant #9's family took her to urgent care the day prior and then picked up an order for an antibiotic. Nitrofurantoin 100 milligram (mg), by mouth twice daily for five days was ordered for a urinary tract infection (UTI). Continued record review revealed a nurse's note was not completed when the antibiotic was completed to follow up if there were any further signs or symptoms of a UTI. 3. Record review on 6/4/26 of Tenant C1's file revealed Observations (nurse's notes) included: a. On 3/27/26, Tenant C1 had a fall in the early morning on 3/26/26 and was seen in the emergency department (ED). He was diagnosed with an ulnar fracture and initially a small subdural hematoma. A second scan completed two hours later showed the fluid decreased and resolved. He returned with new orders to hold Eliquis for seven days and to start Keppra 500 mg, for 7 days. He returned with a sling to wear for comfort but he kept removing the sling so it was taken off.	A 268		

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A 268	Continued From page 39 b. On 3/27/26, staff was informed he fell on Wednesday and a minor brain bleed and fractured elbow. He stood up and was very confused and he was not responding well with verbal cues. Staff assisted him to lay down and he was non-responsive. His blood pressure was 212/152 with a pulse of 54. His pupils were fixed. He was sent to the hospital. c. On 3/28/26, he returned from the hospital at 4:00 a.m. d. On 4/1/26, Tenant C1 appeared off and was not verbally responding. Staff were not able to assist with cares due to him not responding. His oxygen was 70%, his pulse was 116 and pulse was 14. He was sent out to the hospital by ambulance. Continued record review revealed Tenant C1 was discharged, the date provided was 4/8/26 and the reason was a decline in health. A nurse's note failed to be completed to indicate he would not be returning from the hospital and when he was discharged. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed the above finding.	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:	A 274		

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A 274	Continued From page 40 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 interview and record review the Program failed to document incident reports as required. This pertained to 5 of 9 current tenants reviewed (Tenants #1, #3, #7, #8 and #9). Findings follow: 1. Record review on 6/2/26 revealed Tenant #1's Observations (nurse's notes) included: a. On 3/7/26, Tenant #1 was very agitated, threw laundry baskets and bedding at staff. She tried to open the front door to the unit. b. On 4/23/26, Tenant #1 was very agitated that morning. She slammed doors, threw things and was exit seeking at the door when staff arrived at 6:30 a.m. She was upset and staff tried to talk to her and asked if they could help her to the bathroom. She refused all care and staff was able to get her to take her medications. Continued record review revealed there were no incident reports completed related to the incidents noted above. 2. Record review on 6/4/26 revealed Tenant #3's Observations (nurse's note) on 3/15/26 indicated bruising on arms was yellow/brown in color. Tenant #3 was not able to describe how bruising occurred.	A 274		

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A 274	Continued From page 41 Continued record review revealed Tenant #3 ' s incident report, dated 3/15/26 indicated a staff toileted him and discovered bruises on his bilateral arms. Staff asked what happened and he could not tell staff. The on-call nurse was contacted and his spouse was contacted. The incident report lacked a description of the bruises including color, size and location. Further record review revealed Tenant #3's service plan and task records reflected Tenant #3 received assistance from staff with bathing, toileting and dressing. When the bruising of unknown origin was first documented the color of the bruises was noted as yellow and brown (in nurse's notes). Tenant #3 received daily assistance with cares in which the bruising could have been observed and reported prior to 3/15/26, in which the bruises were described as yellow and brown. When interviewed on 6/4/26 at 3:19 p.m. Staff H indicated a couple months ago Tenant #3 had bruising. It was on both sides, exactly the same bruising and there was no way he fell. She thought either another tenant or worker grabbed him, she did not know. Tenant #3 was not able to verbalize what occurred. Tenant #3 received assistance with dressing and bathing. 3. Record review on 6/8/26 revealed Tenant #7's Observations (nurse's notes) included: a. On 4/11/26, Tenant #7 asked staff what color bra they were wearing. b. On 5/2/26, Tenant #7 was having difficulties eating dinner, he choked, threw up at dinner and had tremors. There was a lot of rattling in his lungs and the coughing was loud. Family and	A 274		

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A 274	Continued From page 42	A 274		

hospice talked about putting in an order for thickened liquids and using a syringe for water intake as he aspirated on liquids.

c. On 5/22/26, when staff assisted to change him he tried to unzip staff's sweatshirt and look down their shirt.

Continued record review revealed incident reports were not completed related to the incidents noted above.

4. Record review on 6/8/26 revealed Tenant #8's Observations (nurse's notes) included:

a. On 4/5/26, Tenant #8 expressed suicidal thoughts to staff and said things like if staff did not help her get out she was going to break a window and jump, and if staff did not let her out she was going to kill herself. She also reported hand and back pain.

b. On 6/5/26, Tenant #8 was aggressive towards staff and threatened to kill staff and swung at them.

Continued record review revealed Tenant #8's file incident reports were not completed related to the incidents noted above.

5. Record review on 6/8/26 of Tenant #9's file revealed Observations (nurse's notes) included:

a. On 5/2/26, staff went in at 4:00 a.m. to check on the tenant as other staff were having issues with her cooperating with tasks. She yelled at staff to get out of her room and to stop touching her. Staff attempted to calm her down by reminding her what needed to be done. Tenant #9 tried punching and hitting staff.

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A 274	Continued From page 43 b. On 5/2/26, Tenant #9 was very agitated and aggressive. She hit, slapped and shoved staff. She kept saying she was going to bite staff. c. On 5/8/26, Tenant #9 was very agitated and became combative during evening care. Continued record review revealed Tenant #9's file failed to have completed incident reports for the incidents noted above. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed the above finding.	A 274		
A 280	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with rule 481-69.22(231C) and be designed to meet the specific needs of the individual tenant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans based on the identified needs of the tenants. This pertained to 3 of 9 current tenants reviewed (Tenants #2, #5 and #6). Findings follow: 1. Record review revealed Tenant #2's February and March 2026 medication administration records (MARs) reflected an order for albuterol nebulizer 0.083%, use one vial via nebulizer twice	A 280		

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A 280	Continued From page 44	A 280		

daily. The MAR reflected on 3/4/26 new tubing was needed. On 3/19/26, 3/20/26 and 3/24/26 the MAR indicated it was not administered as it was missing a piece or was awaiting a new part.

Continued record review revealed Tenant #2's service plan dated 1/30/26 reflected Tenant #2 had nebulizer treatment; however, it did not reflect the cleaning of nebulizer after the ordered treatments were completed. It also did not reflect on the MAR.

When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed the nebulizer cleaning was not on the service plan for Tenant #2.

2. Record review on 6/8/26 revealed Tenant #5's evaluation dated 5/13/26, indicated Tenant #5 was incontinent of bladder and bowel incontinence and required assistance from staff. The service plan dated 5/13/26 indicated Tenant #5 would manage toileting needs. He was to use the bathroom and complete toileting tasks as needed without assistance. It also indicated staff would provide assistance with incontinence.

Continued record review revealed the task logs reflected staff assisted with incontinence.

Further record review revealed Tenant #5's service plan failed to provide clear direction or specific service needs related to toileting.

3. Record review on 6/8/26 revealed Tenant #6's evaluation dated 5/13/26, reflected Tenant #6 was incontinent of both bladder and bowel and required assistance from staff. The service plan reflected Tenant #6 would participate to maintain bowel and bladder incontinence care to the fullest

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A 280	Continued From page 45 extent capable. The plan indicated staff provided assistance with Tenant #6's bowel and bladder incontinence. Continued record review revealed Tenant #6's service plan failed to reflect the specific service needs related to toileting. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed all service plans requested were provided for the tenants reviewed.	A 280		
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 update service plans as needed with change in condition. This pertained to 5 of 9 (Tenants #1, #3, #4, #7 and #8) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Record review on 6/2/26 revealed Tenant #1's Observations (nurse's notes) included: a. On 4/24/26, Tenant #1 hit another tenant on	A 282		

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A 282	Continued From page 46 4/22/26 when she was agitated. b. On 4/24/26, Tenant #1 threw water on another tenant. c. On 4/25/26, Tenant #1's family was notified of the elopement and transfer to the hospital. d. On 4/25/26, Tenant #1 returned from the hospital. e. On 4/26/26, woke up that morning and tried to exit the unit. Staff were monitoring closely. f. On 4/27/26, a call was placed to the hospital to see if Tenant #1 had been hospitalized after staff reported family took her out of the building and did not return. She was admitted under observation. She would be most likely discharged that day. g. On 4/30/26, family hired a private caregiver and would be coming in daily 1:00 p.m. to 4:00 p.m. h. On 5/2/26, Tenant #1 tried shaking the chair another tenant was seated in. She opened the doors and staff followed her out. Continued record review revealed Tenant #1 incident report, dated 4/25/26 indicated she came out of her apartment and appeared to be in a bad mood. She threw her make-up bag at another tenant then picked it up and threw it again. She ran down the hallway and pushed on the door. After pushing it a few times, the door opened and set off the alarms. She ran to the elevators on the opposite side of the building. Staff lost sight of her when she went onto a different floor. Staff found her on the second floor. Staff stood in front of the	A 282		

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A 282	Continued From page 47 door so she could not go into the staircase. She started to run but tripped and she fell face first and broke her glasses. Staff got her back to the unit. She was taken to the hospital by paramedics. Further record review revealed Tenant #1 service plans dated 2/17/26 and 5/19/26. Service plans were not completed as needed with changes not above or post elopement. 2. Record review on 6/4/26 of Tenant #3's file revealed Observations (nurse's notes) included: a. On 5/18/26, Tenant #3 seemed more anxious lately. He was whistling more, tried to exit seek, went through things, and slept less. He tried to put things in his mouth despite food being offered. b. On 5/21/26, Tenant #3 chewed his medications. c. On 5/28/26, he was digging things out of the trash can in the night, even when the bag was changed. He was whistling and rocking but smiled at staff. d. On 6/1/26, Tenant #3 was awake most of the night, he went through rooms and had multiple elopement attempts. He showed anxiety all night. He had no as needed medications to help with sleep or anxiety. He had been experiencing those kinds of nights multiple times per week over the past months. Continued record review revealed Tenant #3's service plan was updated on 5/13/26. The service plan failed to be updated as needed with changes noted above.	A 282		

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A 282	Continued From page 48 3. Record review on 6/8/26 revealed Tenant #4's Observations (nurse's notes) included: a. On 3/4/26, Tenant #4 was seen by the primary care provider (PCP) and a new order was received for a calorie supplement three times daily. b. On 3/5/26, a referral was received for hospice on 3/4/26 due to decline and weight loss. Hospice would be coming tomorrow for admission. It was noted a change of condition would be completed related to hospice admission. c. On 3/28/26, Tenant #4 was constantly falling asleep at meals. d. On 4/5/26, Tenant #4 was breathing very hard and deep. Her feet were gray white in color and her hands. Oxygen saturation was 86 %. e. On 4/6/26, hospice was there to follow up on the emergency department (ED) visit. A request was sent for albuterol solution nebulizer treatments four times daily. f. On 5/24/26, Tenant #4's oxygen was put on due to her breathing being off and very heavy. She had a hard time walking. When checked her oxygen was 93%. g. On 5/25/2, Tenant #4 had wheezing and she was constantly falling asleep. Continued record review revealed Tenant #4's service plan was updated on 2/8/26 and 3/6/26. The service plan on 3/6/26 failed to reflect the hospice admission. The service plan failed to be	A 282		

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updated as needed with weight loss, decline, falling asleep including at meals and difficulty breathing.

4. Record review on 6/8/26 revealed Tenant #7's Observations (nurse's notes) indicated the following:

a. On 4/11/26, Tenant #7 asked staff what color bra they were wearing.

b. On 5/2/26, Tenant #7 was having difficulties eating dinner, had choked, threw up at dinner and had tremors. There was a lot of rattling in his lungs and the coughing was loud. Family and hospice talked about putting in an order for thickened liquids and using a syringe for water intake as he aspirated on liquids.

c. On 5/4/26, new orders were received to change the diet to soft with thickened liquids.

d. On 5/22/26, when staff assisted to change him he tried to unzip staff's sweatshirt and look down their shirt.

Continued record review revealed an order was received dated 5/28/26 indicated the diet was soft, bite sized finger foods as tolerated. Food was to be cut into small pieces. Avoid dry, hard crumbly textures, supervision during meals, upright positioning for all intake and to monitor for signs of aspiration.

Further record review revealed Tenant #7's service plan was updated on 4/21/26 and it was not updated as needed with changes in diet and behaviors as noted above.

5. Record review on 6/8/26 revealed Tenant #8's

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A 282	Continued From page 50 Observations (nurse's notes) indicated the following: a. On 4/5/26, Tenant #8 expressed suicidal thoughts to staff and said things like if staff did not help her get out she was going to break a window and jump, and if staff did not let her out she was going to kill herself. She also reported hand and back pain. b. On 4/22/26, Tenant #8 kept saying she wanted to leave and another tenant was bothering her. c. On 4/24/26, a follow up was completed related to a tenant-to-tenant altercation. The other tenant hit Tenant #8 on the back. d. On 5/29/26, she was asking to leave and said she did not want to be there. e. On 6/5/26, Tenant #8 was aggressive towards staff and threatened to kill staff and swung at them. Continued record review revealed Tenant #8's service plan was updated on 5/11/26 (90 day review). The service plan failed to be updated with suicidal ideations, wanting to leave and behaviors with another tenant. 6. Record review on 6/4/26 revealed Tenant C1's Observations (nurse's notes) included: a. On 3/27/26, Tenant C1 had a fall in the early morning on 3/26/26 and was seen in the ED. He was diagnosed with an ulnar fracture and initially a small subdural hematoma. A second scan completed two hours later showed the fluid decreased and resolved. He returned with new orders to hold Eliquis for seven days and to start	A 282		

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A 282	Continued From page 51 Keppra 500 milligrams (mg) for 7 days. He returned with sling to wear for comfort but he kept removing the sling so it was taken off. b. On 3/27/26, staff was informed he had a fall on Wednesday and a minor brain bleed and fractured elbow. He stood up and was very confused and he was not responding well with verbal cues. Staff assisted him to lay down and he was non-responsive. His blood pressure was 212/152 with a pulse of 54. His pupils were fixed. He was sent to the hospital. c. On 3/28/26, he returned from the hospital at 4:00 a.m. d. On 4/1/26, Tenant C1 appeared off and was not verbally responding. Staff were not able to assist with cares due to him not responding. His oxygen was 70%, his pulse was 116 and pulse was 14. He was sent out to the hospital by ambulance. Continued record review revealed Tenant C1's service plan, updated on 3/26/26 but was not updated with changes in responsiveness, increased confusion and changes with cares. 7. Record review on 6/4/26 revealed Tenant C2's Observations (nurse's notes) included: a. On 4/22/26, Tenant C2 had an unwitnessed fall that resulted in a laceration above his right eye and a bloody nose. He was transferred to the ED and returned. He was diagnosed with a bilateral nasal bone fracture and received six sutures to the laceration above the right eye. Orders were received from hospice to hold his Eliquis, start on a soft diet with thickened liquids with a straw. Dietary was notified of the new order.	A 282		

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	S0375	A. BUILDING: _____ B. WING _____	C 06/17/2026

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A 282	Continued From page 52 b. On 4/23/26, hospice brought in a wheelchair to help decrease falls and Eliquis was discontinued due to a high fall risk. c. On 4/25/26, Tenant C2 was urinating on both sides of the recliner. d. On 4/28/26, Tenant C2 seemed to be more calm with a 1:1 caregiver. e. On 5/5/26, Tenant C2's temperature was elevated. f. On 5/6/26, Tenant C2 had a rattle and labored breathing. His feet were swollen and body had signs of stiffening. Morphine was increased to every two hours. g. On 5/7/26, morphine and lorazepam were given throughout the night. Tenant C2's breathing had become more labored. h. On 5/7/26, Tenant C2 was unresponsive at that time and comfort cares were to continue. i. On 5/8/26, Tenant C2 died early that morning. Continued record review revealed Tenant C2's service plan, updated on 4/13/26; however, was not completed with a change in condition with the fall with nasal fracture and lacerations, a wheelchair, discontinuation of the blood thinner, diet changes, changes in urination, a 1:1 caregiver, decline and comfort cares. When interviewed on 6/17/26 the Clinical and Quality Assurance Specialist confirmed the above finding and indicated all service plans requested for the tenants reviewed were provided.	A 282		

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A 305	481-69.28(4) Food Service 481-69.28(231C) Food service. 69.28(4) Therapeutic diets may be provided by a program. If therapeutic diets are provided, they shall be prescribed by a physician, physician assistant, advanced registered nurse practitioner or ordered by a licensed dietitian authorized by a qualified medical provider. A therapeutic diet provides food, fluids or nutrients by oral, enteral, or parenteral routes and is used in the treatment of a disease or clinical condition to modify, eliminate, decrease or increase specific macro- or micronutrients, or to provide mechanically altered food when medically indicated. The thirteenth edition of the Iowa Simplified Diet Manual published by the Iowa dietetic association shall be available and used in the planning and serving of therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and for reviewing procedures for food preparation and service for therapeutic diets. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to provide a licensed dietician for reviewing procedures for food preparation and service for therapeutic diets. This pertained to 1 of 1 current tenant reviewed with a therapeutic diet (Tenant #7). Finding follows: 1. Record review on 6/8/26 revealed Tenant #7's Observations (nurse's notes) included: a. On 5/2/26 Tenant #7 was having difficulties eating dinner, had choked, threw up at dinner and	A 305		

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A 305	Continued From page 54	A 305		

had tremors. There was a lot of rattling in his lungs and the coughing was loud. Family and hospice talked about putting in an order for thickened liquids and using a syringe for water intake as he aspirated on liquids.

b. On 5/4/26, new orders were received to change Tenant #7's diet to soft with thickened liquids.

Continued record review revealed an order dated 5/28/26, indicated the diet was soft, bite sized finger foods as tolerated. Food was to be cut into small pieces. Avoid dry, hard crumbly textures, supervision during meals, upright positioning for all intake and to monitor for signs of aspiration.

Observations on 6/11/26 at 12:00 p.m. at the meal Tenant #7 did not have thickened liquids. A Gatorade in a bottle was provided to him by staff. Also a person was not next to him providing supervision during the time period the meal was observed.

Continued record review revealed menus were provided for the dental soft (mechanical soft) diet. There was no documentation of staff training provided from a licensed dietician regarding how to prepare the food per the ordered diet.

Further record review revealed the Program provided a new order dated 6/11/26, indicated Tenant #7's diet changed to a regular diet, cut into bite size and finger foods.

When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed as of time of the interview Tenant #7 was on a bite sized regular diet. She indicated the Program did not prepare thickened liquids and

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A 305	Continued From page 55 they were all ordered or family could bring in. She confirmed a dietician did not go over techniques with how to prepare the diet. She did not know if Tenant #7's drinks were provided by the Program.	A 305		
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 complete eight hours of dementia specific training for staff within 30 day of employment or contract. This pertained to 4 of 4 agency staff reviewed (Staff J, K, L and M) and 1 of 4 Program staff reviewed (Staff F). Findings follow: 1. Record review on 6/9/26 revealed staff training for dementia education for four agency staff was requested (Staff J, K, L and M). The Owner of the Staffing Agency provided the following information in an email: staff received an initial dementia training that was completed in approximately four hours. Additionally, they received two hours training at the facility they are located. On-going training was provided in-house. a. Staff J ' s training date of 1/12/26	A 330		

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A 330	Continued From page 56 b. Staff K ' s training date of 2/16/26 c. Staff L ' s training date of 8/10/25 d. Staff M ' s training date of 3/5/25 The Owner of the Staffing Agency indicated in the email they were partnering with a state-approved training educator and would ensure eight hours of initial training and eight hours of on-going training. Continued record review, the dates and summary of training was provided above, however, there was no documentation of the training provided and the training indicated above was not eight hours of dementia specific education. 2. Record review on 6/16/26 revealed Staff F's training documents indicated she was hired on 7/2/25 and terminated on 5/3/26. She did not have eight hours of dementia-specific training completed within 30 days of hire. When interviewed on 6/17/26 at 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed no additional training was available. For Staff F her transcript was all that she had.	A 330		