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
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 87 Tenants with cognitive impairment: 8 Total census: 95 The following regulatory insufficiencies were cited related to the investigation of Complaint #131742-C and Complaint #131971-C: ++++++++++++++++++++++++++++++++ 231C.16A Medication setup - administration and storage of medications. 1. An assisted living program may provide for medication setup if requested by a tenant or the tenant's legal representative. If medication setup is provided following such request, the program shall be responsible for the specific task requested and the tenant shall retain responsibility for those tasks not requested to be provided. 2. If medications are administered or stored by an assisted living program, or if the assisted living program provides for medication setup, all of the following shall apply: b. Medications, other than those self-administered by the tenant or provided through medication setup, shall be stored in	A 000	See attached POC 9/25/26	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 000	Continued From page 1 locked storage that is not accessible to persons other than employees responsible for administration or storage of medications. Based on observation, interview and record review the Program failed to store medications in place that was only accessible to staff administering the medications. This potentially affected all tenants that were medication managed (52 tenants). Findings follow: Observations on 6/2/26 at approximately 3:00 p.m. a narcotic count was completed between off-going staff and on-coming staff. The narcotics were located in a tackle or utility box chained to a pillar in a room behind the caregiver station/desk. The box had a combination lock. The box where the narcotics were kept did not have a key only accessible to the staff passing the medications. The box had a combination code (not key). Record review on 6/2/26 of the Program's policy and procedure related to narcotic storage, 4/30/19, indicated if the medications were kept in a central location in the building. Scheduled II, III, IV and V medications were kept under double lock in a locked cabinet or safe designated. The medications would be separate from all other medications and with a different key for access. Only "authorized personnel" had access to controlled substances. When interviewed on 6/17/26 at 11:10 a.m. and 1:37 p.m. the Clinical and Quality Assurance Specialist confirmed on the first shift there were two medication passers. She indicated anyone who passed medications and the nurse had access. She confirmed the box where the	A 000		

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A 000	Continued From page 2 narcotic medications were stored had a code.	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 related to advance directives that affected 2 of 4 current tenants reviewed (Tenant #1 and Tenant #3) and 1 of 3 discharged tenants reviewed (Tenant C2); incident reports, which potentially affected all tenants (census of 95); and narcotic discrepancies that affected 1 of 1 current tenant reviewed with a narcotic discrepancy (Tenant #1). Findings follow: 1. Record review on 5/28/26 and 6/1/26 of Tenant #1's file revealed: a. An incident report, dated 3/15/26 of a medication variance indicated Tenant #1's hydrocodone/APAP count should have been 42 and there were 41 pills left. The locked medication box was unlocked. The Former Licensed Practical Nurse (LPN) was notified. b. The Drug Count Transactions Report indicated on 3/15/26 at 7:25 p.m. an adjustment was made by the Former LPN and noted "Possibly given but not signed out." The Drug Count Report reflected on 3/15/26 at 4:18 p.m. two staff counted 42. On 3/15/26 at 9:50 a.m. two staff counted 41. c. Tenant #1's MAR reflected an order for hydrocodone/APAP, take one tablet every four	A 116		

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A 116	Continued From page 3	A 116		

hours as needed. It was not documented as given between the hours of the two counts listed above 3/15/26.

Continued record review on 6/1/26 revealed the Program's Controlled Substances policy and procedure, dated 10/23/25, indicated if there was an incorrect count, an attempt to find the error would be made. If it could not be verified the medication was given to the tenant, on-coming staff would notify the nurse or director immediately. No staff with access to the controlled substances was to leave the building until the error was resolved or directed to leave. If the cause of the error could be found it was considered a medication error and an incident report would be completed. The nurse or director would adjust the quantity to show the number of narcotics on hand and would enter "a detailed explanation of the reason for the adjustment."

Further record review revealed Tenant #1's file lacked a detailed explanation related to discrepancy in the narcotic count for Tenant #1 or the adjustment made to reconcile the count.

2. Record review on 5/28/26 and 6/1/26 of Tenant #1's file revealed she did not have an advance director or an advance directive acknowledgement form. The file also lacked evidence that one had been provided.

Record review on 5/28/26 of Tenant #3's file revealed he did not have an advance directive or advance directive acknowledgement form. The file also lacked documentation that one had been requested.

Record review on 5/28/26 and 6/1/26 of Tenant

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A 116	Continued From page 4 C2's file revealed she did not have an advance directive or advance direction acknowledgement form. The file also lacked documentation that one had been requested. (See 67.3(2) for additional information) Continued record review on 5/27/26 revealed the Program's Advance Medical Directive policy and procedure, 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 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. 3. Record review on 6/1/26 of the May 2026 incident reports revealed the incident reports lacked required information including recorded vitals signs, witness name and contact number and the name of the person completing the report. Record review on 5/26/26 of the Program's policy and procedure for incident reports, 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.	A 116		

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A 116	Continued From page 5 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. When interviewed on 6/17/26 at 11:10 a.m. the Clinical and Quality Assurance Specialist confirmed the above finding.	A 116		
A 122	481-67.3(2) Tenant Rights 481-67.3(231B,231C,231D) Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services that are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide adequate and appropriate services related to a tenant found unresponsive. This pertained to 1 of 3 discharged tenants reviewed (Tenant C2). Findings follow: 1. Record review on 5/28/26 and 6/1/26 of Tenant C2's file revealed an incident report dated 3/27/26 indicated staff went to Tenant C2's apartment at 8:11 p.m. to administer her medications, staff heard two gurgling sounds and checked on her. She was in bed and	A 122		

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A 122	Continued From page 6	A 122		

unresponsive to sternal rub, staff calling her name and tapping her. Her respiration rate was 14. Tenant C2 was sent to the hospital. There was no code status listed and family said to have her as a full code.

2. Continued record review revealed Observations(nurse's notes) indicated the following:

-On 3/27/26 it was noted a nurse was called by staff due to the tenant being unresponsive. Staff were instructed to call 911 and stay with Tenant C2. She was transferred to the hospital. An update was received by family that indicated Tenant C2 was intubated.

-On 4/9/26 it was noted hospital staff reported family was planning to have Tenant C2 discharged to a long-term care facility closer to family and hospice was being considered.

3. When interviewed on 6/1/26 at 2:00 p.m. Staff E said she was not working when Tenant C2 went out to the hospital but around the time it happened Tenant C2 had incontinence issues, was not walking, could not dress herself. She said it happened about a month before and was progressive.

When interviewed on 6/1/26 at 3:15 p.m. Staff F said Tenant C2 needed more assistance with walking, and some toileting. Staff helped with medications and she generally dressed herself. At about 8:00 p.m. another staff called her and said Tenant C2 was unresponsive. She was laying flat on her back on her bed, breathing, she would not tilt her head back, and was rigid. The nurse was called and emergency medical services (EMS) were called. Staff had to call

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A 122	Continued From page 7 Tenant C2's family to figure out her code status, it was not in her apartment. 4. Further record review revealed the evaluations and service plan for Tenant C2 did not reflect the increased care needs as noted in staff interviews. Tenant C2's service plan reflected she was independent with mobility and transfers, toileting and dressing. A meal log indicated the last meal Tenant C2 attended in the dining room was on 3/27/26 at 9:37 a.m. (breakfast). Tenant C2 was found unresponsive at 8:11 p.m. and there were no recorded meals for the lunch or dinner meal on 3/27/26. The March 2026 medication administration records (MARs) reflected Tenant C2 had medications administered by staff at 12:00 p.m. and 4:00 p.m. 5. Continued record review revealed hospital records indicated Tenant C2 was last known normal at 3:00 p.m. She was found down by staff who called EMS. She was intubated. She was seen in the emergency department (ED) in January 2026 for altered mental status "thought to be related to missed doses of Sinemet." At that time Tenant C2 reported dissatisfaction with her care related to lack of medication support and skin care. The assessment and plan indicated she was admitted to the medical intensive care unit with concern for levodopa withdrawal syndrome in the setting of potential missed Sinemet doses. She was critically ill due to central nervous system failure. "Ultimately neuro felt that her presentation was consistent with progression of Parkinson's disease."	A 122		

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A 122	Continued From page 8 Further record review revealed Tenant C2 did not receive services that were adequate and appropriate as she was not checked on when she missed two meals prior to being found unresponsive at 8:11 p.m. Additionally, her cares and services were not updated to reflect increased cares needs prior to the unresponsive episode. At the time of the incident an advance directive could not be found and Tenant C2's legal representative was called to provide a declaration of code status during the incident. When interviewed on 6/17/26 at 11:10 a.m. the Clinical and Quality Assurance Specialist indicated on her last evaluation it was noted she did not want well checks, she declined during the day and night. She said it was a resident right issue, they could knock (at the door).	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 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 administer medications and	A 152		

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A 152	Continued From page 9	A 152		

treatments as ordered. This pertained to 3 of 4 current tenants reviewed (Tenants #1, #2 and #3) and 1 of 3 discharged tenants reviewed (Tenant C3). Findings follow:

1. Record review on 5/27/26 of Tenant #1's file revealed staff administered her medications. A provider document reflected orders including for Accu-Chek one strip twice daily for monitoring blood sugar. It was signed electronically by the provider on 4/10/26.

Continued record review revealed April and May 2026 medication administration records (MARs) reflected True Metrix test glucose, use one strip every day. It reflected blood glucose monitoring once daily at 8:00 a.m. The May 2026 MAR reflected an order for Easy Touch MIS P-AC, use to check blood glucose twice daily on the MAR with an issue date of 3/30/26. It was shaded and there were no documented entries on the MARs.

Further record review revealed the March to May 2026 MARs reflected an order for hydrocodone/APAP take one tablet every four hours as needed (dosing varied). It was consistently administered in March (all but one day) and the effectiveness of the medication was not documented with each administration of the as needed medication.

2. Record review on 5/27/26 and 5/28/26 of Tenant #2's file revealed a diagnosis of diabetes mellitus type 2. Observations (nurse's notes) indicated the following:

-On 3/5/26, orders were received to discontinue sliding scale insulin and start Tresiba 100 flex touch 100 unit/milliliters (ml), inject 16 units daily and Novolog flex pen inject 2 units, three times

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A 152	Continued From page 10 per day for blood glucose greater than 150. -On 3/17/26, a call was placed to pharmacy requesting the insulin delivered sooner as Tenant #2's blood glucose was high due to being out of insulin. Pharmacy indicated they would send it out as soon as possible. -On 3/17/26, a call was placed to the primary care provider's (PCP) office regarding Tenant #2's blood glucose levels. -On 3/17/26, the medication manager on duty notified the nurse Tenant #2's blood glucose was 495 and he did not have any more insulin for the night. The nurse called and spoke to the on-call provider. Due to advanced age and lack of symptoms he did not want to give extra insulin at that time and to call back with any symptoms. -On 3/18/26, the continuous glucometer sensor was added to the as needed orders. -On 3/19/26, Tenant #2's blood glucose was 497 and he was asymptomatic. A new order was received to increase Novolog to 6 units three times daily. Continued record review revealed the March 2026 medication administration records (MARs) reflected the following: -Tresiba Flex injection 100 unit, inject 16 units, under the skin every day at 8:00 a.m., indicated a start date of 3/4/26 and documented as administered from 3/5/26 to 3/11/26. On 3/12/26 it was not documented as administered and from 3/13/26 to 3/17/26 the medication was not documented as administered due to not being available.	A 152		

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A 152	Continued From page 11 Tenant #2's blood glucose readings during that time period and after included the following: -On 3/12/26 at 8:00 a.m. it was 249, at 12:00 p.m. it was 319 and at 5:00 p.m. it was 339 -On 3/13/26 at 5:00 p.m. it was 353 -On 3/14/26 there were no blood glucose readings documented -On 3/15/26 at 5:00 p.m. it was 285 -On 3/16/26 at 4:00 p.m. it was 551 -On 3/17/26 at 7:00 a.m. it was charted as refused, at 11:00 a.m. charted as 564 and 4:00 p.m. charted as 483 -On 3/18/26 at 7:00 a.m. it was 513, at 11:00 a.m. it was 518 and at 4:00 p.m. at 535 -On 3/19/26 at 4:00 p.m. it was 497 -On 3/23/26 at 7:00 a.m. it was 430, at 11:00 a.m. it was 406 -On 3/25/26 at 7:00 a.m. it was 409 3. Record review on 5/28/26 of Tenant #3's file revealed staff administered his medications. The April 2026 MAR reflected an order for Atorvastatin 40 milligrams (mg), take half tablet by mouth every day. It was documented as medication not available eight times. It was documented as discontinued or not taking the medication four times. Review of the orders and subsequent MARs did not reflect the order was discontinued. The May 2026 MAR reflected seven times the	A 152		

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A 152	Continued From page 12	A 152		

medication was not available to administer.

The May 2026 MAR also reflected famotidine 20 mg tablet, which was not available to administer on 5/18/26. The MAR reflected metoprolol succinate 25 mg ER tablet, take half tablet every night was not available to administer on 5/18/26.

4. Record review on 6/2/26 of Tenant C3's file revealed diagnoses included a metastatic small bowel neuroendocrine tumor. Tenant C3 received staff assistance with medications.

Continued record review revealed an After Visit Summary with a list of medications that included an order for INQOVI, 35-100 milligram (mg) per tablet. Take one tablet by mouth daily. Take on days 1-3 (1/27/26 to 1/29/26) on an empty stomach. Keep the extra tablets for future use.

Further record review revealed the January 2026 MAR reflected the order for INQOVI tablet 35-100 mg, take one tablet by mouth every day, take on days 1-3 (1/27/26 to 1/29/26) on an empty stomach. The MAR reflected no doses were administered in January. On 1/31/26 it was documented, medication not available. The February 2026 MAR reflected on 2/1/26 the medication was not available to administer. It was documented as administered from 2/2/26 to 2/6/26; despite being ordered to be given for three days (1/27/26 to 1/29/26). Doses on 2/7/26 and 2/8/26 were documented as refused.

The January 2026 MAR also reflected an order for ondansetron tablets to take one tablet by mouth at least every 30 minutes prior to each dose of INQOVI and may take up to every eight hours as needed for nausea. It had a start date of 1/27/26. In February a tablet of ondansetron

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A 152	Continued From page 13	A 152		

was administered prior to the doses on 2/2/26 and 2/3/26; however, was not administered prior to the doses administered on 2/4/26, 2/5/26 or 2/6/26.

Continued record review revealed an order was received for INQOVI 35-100 mg tablet, take one tablet by mouth daily take on days 1-3 (3/13/26 to 3/15/26) on an empty stomach. Keep the extra tablets for future use. The start date was 3/11/26.

Further record review revealed the March 2026 MAR reflected the order for INQOVI tablet 35-100 mg, take one tablet by mouth every day, take on days 1-3. The MAR reflected a dose was administered on 3/13/26, it was charted as not available on 3/14/26 and was documented on 3/15/26.

The March 2026 MAR also reflected an order for ondansetron tablet, to take one tablet by mouth at least every 30 minutes prior to each dose of INQOVI and may take up to every eight hours as needed for nausea. It had a start date of 1/27/26. There were no recorded doses of ondansetron administered despite doses of INQOVI administered on 3/13/26 and 3/15/26.

It should be noted INQOVI is anti-cancer medication and there was importance noted to be administered in consecutive doses and it had an ordered number of days to be administered.

When interviewed on 6/17/26 at 11:10 a.m. the Clinical and Quality Assurance Specialist indicated the nurse and medication technician called the pharmacy every day related to Tenant #2's medication. She communicated the expectation was that the outcome of as needed medications should be charted before the end of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 152	Continued From page 14 the staff's shift. She indicated there was no explanation related to Tenant C3's medication (issue noted above). She mentioned Tenant #1's blood glucose (order) had changed. She confirmed Tenant #3's medications were charted as not available at times. She confirmed all MARs and ordered requests 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 a sufficient number of trained staff to meet the tenants' identified needs. This potentially affected all tenants (census of 95). Findings follow: When interviewed 6/1/26 at 2:00 p.m. Staff E explained the assisted living side was supposed to have three staff on her shift but today they were short. There was enough staff when it was fully staffed but she indicated at least weekly they worked short-staffed. She indicated some staff said they did something but they did not do it (regarding services provided to tenants), primarily when it came to linen changes and showers. When interviewed on 6/1/26 at 3:15 p.m. Staff F indicated agency staff would sometimes mark medications passed and not pass them. Staff F reported it varied if services were provided or not, primarily when it came to linens. She mentioned	A 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 191	Continued From page 15	A 191		

most of the agency staff were not helping with showers. Program staff generally tried to pick up the showers. She indicated staff tried to answer pendants in 20 minutes or less.

When interviewed on 5/27/26 at 10:50 a.m. Staff G indicated regarding services provided to tenants that sometimes things were missed and things were not getting done.

One tenant interview was attempted and when the surveyor knocked the tenant said she was waiting for her shower and asked when it would be. The surveyor reported the issue to leadership staff. Another attempt was made to interview the tenant on 6/3/26 at approximately 11:15 a.m. and she could not give an average response to the pendant. It varied on if there was an emergency situation, if they were short staffed.

Record review on 6/01/26 revealed the Recorded Care Reports (task logs) for current Tenants #1, #3, #4 and discharged Tenants C1 and C2 reflected tenant services were documented after the time of the scheduled services.

Continued record review on 6/1/26 of pendant responses revealed pendant response times were reviewed from 5/29/26 to 5/31/26 and reflected the following:

-On 5/29/26 there were over 10 pendant responses greater than 15 minutes. Examples included one time that reflected over one hour (for toileting) and one time for over two hours (need for a nurse).

-On 5/30/26 there were over 20 pendant responses greater than 15 minutes. Examples included one time for over two hours (for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

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

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A 191	Continued From page 16 toileting), one time for over an hour (for an escort). -On 5/31/26 there were over 10 pendant responses greater than 15 minutes. An example included one time over 50 minutes (for toileting). When interviewed on 6/17/26 at 11:10 a.m. the Clinical and Quality Assurance Specialist explained there was not an exact time for pendant response and nothing in policy and procedure. She indicated the expectation was between 10 to 15 minutes.	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 by: Based on interview and record review the Program failed to maintain staff training records. This pertained to 4 of 4 agency staff reviewed (Staff A, B, C and D). Findings follow: Record review on 6/1/26 revealed invoices for a staffing agency for March, April and May 2026 indicated Staff A, B, C and D worked at the Program in that time period. Continued record review revealed training and hiring materials were requested for agency staff	A 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

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

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A 193	Continued From page 17 including background checks and nurse delegation training. The Program did not maintain a copy of the background checks to ensure background checks were completed by the staffing agency prior to working at the Program. Additionally, no nurse delegation training documents were maintained for Staff A, B, C and D (agency staff). When interviewed on 6/17/26 at 11:10 a.m. the Clinical and Quality Assurance Specialist confirmed the above finding.	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. 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 4 of 4 agency staff reviewed (Staff A, B, C and D). Findings follow: Record review on 6/1/26 revealed invoices for a staffing agency for March, April and May 2026 indicated Staff A, B, C and D worked at the	A 198		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

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

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A 198	Continued From page 18 Program (agency staff) in that time period. Continued record review revealed nurse delegation training was not completed by the Program's delegating nurse for Staff A, B, C and D (agency staff). When interviewed on 6/17/26 at 11:10 a.m. the Clinical and Quality Assurance Specialist confirmed the above finding.	A 198		
A 309	481-67.18(3)b Record Checks 481-67.18(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.18(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall complete the background check requirements set forth below. b. Conducting a background check. The program will either request that the department of public safety perform a criminal history check and that HHS perform child and dependent adult abuse record checks of the person in this state or access the single contact repository (SING) to perform the required background check. If SING is used, the program will submit the person's maiden name, if applicable, with the background check request. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete background checks	A 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 309	Continued From page 19	A 309		

or ensure background checks were completed prior to staff working for 4 of 4 agency staff reviewed (Staff A, B, C and D). Findings follow:

Record review on 6/1/26 revealed invoices for a staffing agency for March, April and May 2026 indicated Staff A, B, C and D worked at the Program in that time period.

Record review on 6/1/26 of Staff A's training information indicated a Iowa Sing Result Summary indicated a background check was completed on 4/1/26 and no records were found in the abuse registry. A record was found in the criminal history registry on 4/3/26. An approval notice was received dated 4/28/26 indicated Staff A could work. Invoice records indicated Staff A worked at the Program prior to the completion of the background check and approval notification.

Record review on 6/1/26 of Staff B's training information indicated a consumer report through Checkr was provided dated 3/3/25; however, an approved background check was not completed. Invoice records provided indicated Staff B worked at the Program without a completed approved background check.

Record review on 6/1/26 of Staff C's training information indicated Staff C had a Iowa Sing Result Summary completed on 6/1/26. The background check did not indicate any results found for the abuse registries or criminal history background check. Invoice records provided indicated Staff C worked at the Program prior to the completion of the background check.

Record review on 6/1/26 of Tenant D's training information indicated Staff D had a Iowa Sing Result Summary completed on 6/1/26. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

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

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A 309	Continued From page 20 background check did not indicate any results found for the abuse registries or criminal history background check. Invoice records provided indicated Staff C worked at the Program prior to the completion of the background check. When interviewed on 6/17/26 at 11:10 a.m. the Clinical and Quality Assurance Specialist confirmed no additional background checks were provided for agency staff.	A 309		
A 227	481-69.21(3) Occupancy Agreement 481-69.21(231C) Occupancy agreement. 69.21(3)The occupancy agreement shall be reviewed and updated as necessary to reflect any change in services or financial arrangements. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update the occupancy agreement to reflect any change in services related to not providing sliding scale insulin. This affected 1 of 1 tenant reviewed that had sliding scale insulin (Tenant #2). Findings follow: Record review on 5/27/26 and 5/28/26 of Tenant #2's file revealed a diagnosis of diabetes mellitus type 2. Tenant #2 was admitted to the Program on 11/29/2019. Observations (nurse's notes) indicated on 3/5/26 orders were received to discontinue sliding scale insulin and start Tresiba 100 flex touch 100 unit/milliliters (ml), inject 16 units daily and Novolog flex pen inject 2 units, three times per day for blood glucose greater than 150.	A 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 227	Continued From page 21 When interviewed on 6/2/26 at 9:15 a.m. the Clinical and Quality Assurance Specialist indicated tenants were changed from sliding scale insulin to scheduled with parameters. It was not in a policy and procedure. It was expressed verbally. Continued record review of Tenant #2's occupancy agreement signed most recently on 9/25/25 with the current company(change of management July 2025). The occupancy agreement did not reflect sliding scale insulin could not be provided and the occupancy agreement was not updated to reflect change in services. Further record review revealed Tenant #2 resided at the Program since 2019. The new management company took over in July 2025. They did not allow sliding scale insulin (unless with nurses on the floor) and switched all tenants with sliding scale insulin over to scheduled units, including Tenant #2. The occupancy agreement was not updated to reflect a change in services with the new management company related to not providing sliding scale insulin. When interviewed on 6/17/26 at 11:10 a.m. the Clinical and Quality Assurance Specialist indicated they did not provide sliding scale insulin due to not having 24 hour nursing. She explained there were three tenants that were switched over from sliding scale and Tenant #2 was the last one. Communication was verbal regarding not providing a sliding scale and she had not received any push back on the change. She confirmed there was nothing in writing regarding the sliding scale insulin and nothing in the occupancy agreement.	A 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

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

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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 by: Based on interview and record review the Program failed to complete evaluations as needed. This pertained to 1 of 4 current tenants reviewed (Tenant #3) and 2 of 3 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Record review on 5/28/26 of Tenant #3's file revealed Observations (nurse's notes) indicated the following: -On 4/3/26, staff found Tenant #3 on the floor and he was incontinent of urine. -On 4/10/26, Tenant #3 was "soaked." His bed and couch were also noted as "soaked." -On 4/11/26, Tenant #3 refused cares all night and had been on the couch since 2:30 a.m. Staff returned at 6:00 a.m. and he was still on the couch, refused to get up and get changed. -On 4/12/26, staff checked on Tenant #3's more	A 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

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

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A 232	Continued From page 23 with his spouse out at the hospital . -On 4/13/26, staff checked on Tenant #3 and noted a pink discoloration in his briefs. -On 4/14/26, an order was requested for a urinalysis (UA) with culture and sensitivity. -On 4/15/26, UA results were received and were faxed to the primary care provider (PCP). Continued record review of Tenant #3's file revealed evaluations were completed on 4/29/26; however, were not completed with increased urinary incontinence, care refusals, discoloration in the brief a request for a UA that occurred prior to the evaluation update on 4/29/26. 2. Record review on 5/28/26 and 6/1/26 of Tenant C1's file revealed Observations (nurse's notes) indicated the following: -On 3/27/26, noted a behavior change, staff spent over 30 minutes and Tenant C1 refused to get ready for bed or take off her socks. Staff went back several times and she refused but let staff remove her anti-embolism hose and elevate her legs. -On 3/28/26, noted a behavior change, Tenant C1 was very slow and refused cares. She took two of her medications after 15 minutes of staff encouraging her and refused to take her last several medications. Tenant C1 refused to sit on the couch or go to bed and was in her wheelchair. It was noted staff spent over 40 minutes in her apartment attempting to get her to do cares and to keep her safe. Staff did not want to leave her in the wheelchair for hours.	A 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 232	Continued From page 24 -On 3/31/26, Tenant C1 refused to get up off the couch and get ready for bed. Staff had been in the apartment every hour and she still refused. -On 4/1/26, three staff checked on her and encouraged her to bed. She refused to go to the bathroom, and refused to change her clothes. Her legs appeared very swollen. -On 4/4/26, staff attempted to remove Tenant C1's anti-embolism hose and she raised her hand. Tenant C1 was more combative and had increased agitation. -On 4/4/26, staff assisted Tenant C1 with wiping her and felt a "lump in the vaginal area." It was observed by staff that there was a "ball-shaped lump poking out of her vaginal canal." -On 4/10/26, staff changed Tenant C1's brief, she was very shaky, her legs were swollen and she had sore on her "bottom." -On 4/11/26, Tenant C1 refused to get up. Tenant C1 was "soaking wet and sheets were wet too." Staff were in her apartment for a hour and a half. -On 4/27/26, all scheduled medications were discontinued by hospice. -On 4/28/26, as needed medications were given around the clock and she was resting in bed. -On 4/29/26, staff changed and repositioned Tenant C1. -On 4/30/26, Tenant C1 died. Continued record review of Tenant C1's file revealed evaluations were completed on 4/17/26	A 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 232	Continued From page 25	A 232		

and 4/22/26 for changes in condition; however, evaluations were not completed until 4/17/26 despite changes as noted above. Additionally, evaluations were not completed after 4/22/26, as needed with the discontinuation of scheduled medications and comfort cares including changing and repositioning.

3. Record review on 5/28/26 and 6/1/26 of Tenant C2's file revealed a discharge date of 5/1/26 and the reason indicated she left to a higher level of care. Observations (nurse's notes) indicated the following:

-On 3/27/26, a nurse was called by staff due to the tenant being unresponsive. Staff were instructed to call 911 and stay with Tenant C2. She was transferred to the hospital. An update was received by family that indicated Tenant C2 was intubated.

-On 4/9/26, hospital staff reported family was planning to have Tenant C2 discharged to a long-term care facility closer to family and hospice was being considered.

When interviewed on 6/1/26 at 2:00 p.m. Staff E indicated she was not working when Tenant C2 went out to the hospital but around the time it happened Tenant C2 had incontinence issues, was not walking, could not dress herself. This happened about a month before and was progressive.

When interviewed on 6/1/26 at 3:15 p.m. Staff F explained Tenant C2 needed more assistance with walking, and some toileting. Staff helped with medications and she generally dressed herself. At about 8:00 p.m. another staff called her and said Tenant C2 was unresponsive. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 232	Continued From page 26 was laying flat on her back on her bed, breathing, she would not tilt her head back, and was rigid. The nurse was called and emergency medical services (EMS) were called. Staff called Tenant C2's family to figure out her code status; it was not in her apartment. Continued record review of Tenant C2's file revealed the most recent evaluation was dated 2/28/26. The evaluation indicated Tenant C2 was independent with toileting, mobility and transfers and dressing. Evaluations were not updated as needed to reflect the change in Tenant C2's condition as noted above. When interviewed on 6/17/26 at 11:10 a.m. the Clinical and Quality Assurance Specialist confirmed the evaluations requested were provided.	A 232		
A 268	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception; This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 268		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 268	Continued From page 27 Program failed to document nurse's notes by exception. This pertained to tenant 1 of 3 current tenants reviewed (Tenant #3) and 1 of 3 discharged tenants reviewed (Tenant C2). Findings follow: 1. Record review on 5/28/26 of Tenant #3's file revealed Observations (nurse's notes) indicated the following: -On 4/3/26, staff found Tenant #3 on the floor and he was incontinent of urine. -On 4/10/26, Tenant #3 was "soaked." His bed and couch were also noted as "soaked." -On 4/11/26, Tenant #3 refused cares all night and had been on the couch since 2:30 a.m. Staff returned at 6:00 a.m. and he was still on the couch, refused to get up and get changed. -On 4/12/26, staff checked on Tenant #3's more with his spouse out at the hospital. . -On 4/13/26, staff checked on Tenant #3 and noted a pink discoloration in his briefs. -On 4/14/26, an order was requested for a urinalysis (UA) with culture and sensitivity. -On 4/15/26, UA results were received and were faxed to the primary care provider (PCP). Continued record review revealed Tenant #3's nurse's note was not documented related to the results of the UA and to monitor for any further episodes of significant urinary incontinence and discoloration in his brief. 2. Record review on 5/28/26 and 6/1/26 of	A 268		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 268	Continued From page 28 Tenant C2's file revealed a discharge date of 5/1/26 and the reason indicated she left to a higher level of care. Observations (nurse's notes) indicated the following: -On 3/27/26, a nurse was called by staff due to the tenant being unresponsive. Staff were instructed to call 911 and stay with Tenant C2. She was transferred to the hospital. An update was received by family that indicated Tenant C2 was intubated. -On 4/9/26, hospital staff reported family was planning to have Tenant C2 discharged to a long-term care facility closer to family and hospice was being considered. Continued record review revealed Tenant C2's nurse's note was not completed related to Tenant C2's hospitalization or a discharge note when she was discharged from the Program. When interviewed on 6/17/26 at 11:10 a.m. the Clinical and Quality Assurance Specialist explained for Tenant #3 the note indicated the UA results were faxed to the PCP. She said they could not enter in notes when the tenant was off premises.	A 268		
A 274	481-69.25(1)o Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: o. Incident reports involving the tenant, including but not limited to those related to	A 274		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 274	Continued From page 29	A 274		

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 complete incident reports as required. This pertained to 1 of 1 current tenant reviewed with missed insulin doses (Tenant #2) and 1 of 3 discharged tenants reviewed (Tenant C3). Findings follow:

1. Record review on 5/27/26 and 5/28/26 of Tenant #2's file revealed a diagnosis of diabetes mellitus type 2. Tenant #2 received staff assistance with medication administration. Observations (nurse's notes) indicated the following:

-On 3/5/26, orders were received to discontinue sliding scale insulin and start Tresiba 100 flex touch 100 unit/milliliters (ml), inject 16 units daily and Novolog flex pen inject 2 units, three times per day for blood glucose greater than 150.

-On 3/17/26, a call was placed to pharmacy requesting the insulin delivered sooner as Tenant #2's blood glucose was high due to being out of insulin. Pharmacy indicated they would send it out as soon as possible.

-On 3/17/26, a call was placed to the primary care provider's (PCP) office regarding Tenant #2's blood glucose levels.

-On 3/17/26, the medication manager on duty notified the nurse Tenant #2's blood glucose was 495 and he did not have any more insulin for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 274	Continued From page 30	A 274		

night. The nurse called and spoke to the on-call provider. Due to advanced age and lack of symptoms he did not want to give extra insulin at that time and to call back with any symptoms.

-On 3/18/26, the continuous glucometer sensor was added to the as needed orders.

-On 3/19/26, Tenant #2's blood glucose was 497 and he was asymptomatic. A new order was received to increase Novolog to 6 units three times daily.

Continued record review revealed the March 2026 medication administration records (MARs) indicated Tresiba Flex injection 100 unit, inject 16 units, under the skin every day at 8:00 a.m. It reflected a start date of 3/4/26 and documented as administered from 3/5/26 to 3/11/26. On 3/12/26 it was not documented as administered and from 3/13/26 to 3/17/26 the medication was not documented as administered due to not being available.

Further record review of Tenant #2's file revealed an incident report was not completed related to medication error noted above and the insulin not administered as ordered.

2. Record review on 6/2/26 of Tenant C3's file revealed diagnoses included metastatic small bowel neuroendocrine tumor. Tenant C3 received staff assistance with medications.

Continued record review revealed an After Visit Summary reflected a list of medications that included an order for INQOVI, 35-100 milligram (mg) per tablet. Take one tablet by mouth daily. Take on days 1-3 (1/27/26 to 1/29/26) on an empty stomach. Keep the extra tablets for future

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 274	Continued From page 31 use. Further record review revealed the January 2026 MAR reflected the order for INQOVI tablet 35-100 mg, take one tablet by mouth every day, take on days 1-3 (1/27/26 to 1/29/26) on an empty stomach. The MAR reflected no doses were administered in January. On 1/31/26 it was documented that medication was not available. The February 2026 MAR reflected on 2/1/26 the medication was not available to administer. It was documented as administered from 2/2/26 to 2/6/26; despite being ordered to be given for three days (1/27/26 to 1/29/26). Doses on 2/7/26 and 2/8/26 were documented as refused. The January 2026 MAR also reflected an order for ondansetron tablet take one tablet by mouth at least every 30 minutes prior to each dose of INQOVI and may take up to every eight hours as needed for nausea. It had a start date of 1/27/26. In February a tablet of ondansetron was administered prior to the doses on 2/2/26 and 2/3/26; however, was not administered prior to the doses administered on 2/4/26, 2/5/26 or 2/6/26. Continued record review revealed an order received for INQOVI 35-100 mg tablet, take one tablet by mouth daily take on days 1-3 (3/13/26 to 3/15/26) on an empty stomach. Keep the extra tablets for future use. The start date was 3/11/26. Further record review revealed the March 2026 MAR reflected the order for INQOVI tablet 35-100 mg, take one tablet by mouth every day, take on days 1-3. The MAR reflected a dose was administered on 3/13/26, it was charted as not available on 3/14/26 and was documented on 3/15/26.	A 274		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 274	Continued From page 32 The March 2026 MAR also reflected an order for ondansetron tablet take one tablet by mouth at least every 30 minutes prior to each dose of INQOVI and may take up to every eight hours as needed for nausea. It had a start date of 1/27/26. There were no recorded doses of ondansetron administered despite doses of INQOVI administered on 3/13/26 and 3/15/26. It should be noted INQOVI is anti-cancer medication and there was importance noted to be administered in consecutive doses and it had an ordered number of days to be administered. Further record review of Tenant C3's file revealed incident reports were not completed related to the medication errors noted above. When interviewed on 6/17/26 at 11:10 a.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 that reflected the service needs of the tenants. This	A 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 280	Continued From page 33	A 280		

pertained to tenants reviewed 2 of 4 current tenants reviewed (Tenant #2 and Tenant #4). Findings follow:

1. Record review on 5/27/26 and 5/28/26 of Tenant #2's file revealed a diagnosis of diabetes mellitus type 2. Observations (nurse's notes) indicated the following:

-On 3/5/26, orders were received to discontinue sliding scale insulin and start Tresiba 100 flex touch 100 unit/milliliters (ml), inject 16 units daily and Novolog flex pen inject 2 units, three times per day for blood glucose greater than 150.

-On 3/17/26, a call was placed to pharmacy requesting the insulin delivered sooner as Tenant #2's blood glucose was high due to being out of insulin. Pharmacy indicated they would send it out as soon as possible.

-On 3/17/26, a call was placed to the primary care provider's (PCP) office regarding Tenant #2's blood glucose levels.

-On 3/17/26, the medication manager on duty notified the nurse Tenant #2's blood glucose was 495 and he did not have any more insulin for the night. The nurse called and spoke to the on-call provider. Due to advanced age and lack of symptoms he did not want to give extra insulin at that time and to call back with any symptoms.

-On 3/18/26, the continuous glucometer sensor was added to the as needed orders.

-On 3/19/26, Tenant #2's blood glucose was 497 and he was asymptomatic. A new order was received to increase Novolog to 6 units three times daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 280	Continued From page 34 Continued record review of Tenant #2's file revealed Tenant #2's service plan did not reflect the use of a continuous glucometer and who managed the sensor changes. 2. Record review on 6/1/26 of Tenant #4's file revealed the March, April and May 2026 medication administration records (MARs) reflected at times Tenant #4's refused her medications. The service plan reflected staff administered her medications; however, did not reflect the medication refusals. When interviewed on 6/17/26 at 11:10 a.m. the Clinical and Quality Assurance Specialist indicated for Tenant #2 it appeared that staff were completing finger sticks for his blood glucose. She confirmed the above finding for Tenant #4.	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 significant change. This pertained to 1 of 4 current tenants reviewed (Tenant #3) and 2 of 3	A 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 282	Continued From page 35	A 282		

discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow

1. Record review on 5/28/26 of Tenant #3's file revealed Observations (nurse's notes) indicated the following:

-On 4/3/26, staff found Tenant #3 on the floor and he was incontinent of urine.

-On 4/10/26, Tenant #3 was "soaked." His bed and couch were also noted as "soaked."

-On 4/11/26, Tenant #3 refused cares all night and had been on the couch since 2:30 a.m. Staff returned at 6:00 a.m. and he was still on the couch, refused to get up and get changed.

-On 4/12/26, staff checked on Tenant #3's more with his spouse out at the hospital
.
-On 4/13/26, staff checked on Tenant #3 and noted a pink discoloration in his briefs.

-On 4/14/26, an order was requested for a urinalysis (UA) with culture and sensitivity.

-On 4/15/26, UA results were received and were faxed to the primary care provider (PCP).

Continued record review of Tenant #3's file revealed the service plan was updated on 4/29/26; however, was not updated with increased urinary incontinence, care refusals, discoloration in the brief a request for a UA that occurred prior to the evaluation update on 4/29/26.

2. Record review on 5/28/26 and 6/1/26 of Tenant C1's file revealed Observations (nurse's notes)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 282	Continued From page 36 indicated the following: -On 3/27/26, noted a behavior change, staff spent over 30 minutes and Tenant C1 refused to get ready for bed or take off her socks. Staff went back several times and she refused but let staff remove her anti-embolism hose and elevate her legs. -On 3/28/26, noted a behavior change, Tenant C1 was very slow and refused cares. She took two of her medications after 15 minutes of staff encouraging her and refused to take her last several medications. Tenant C1 refused to sit on the couch or go to bed and was in her wheelchair. It was noted staff spent over 40 minutes in her apartment attempting to get her to do cares and to keep her safe. Staff did not want to leave her in the wheelchair for hours. -On 3/31/26, Tenant C1 refused to get up off the couch and get ready for bed. Staff had been in the apartment every hour and she still refused. -On 4/1/26, three staff checked on her and encouraged her to bed. She refused to go to the bathroom, refused changing her clothes. Her legs appeared very swollen. -On 4/4/26, staff attempted to remove Tenant C1's anti-embolism hose and she raised her hand. Tenant C1 was more combative and had increased agitation. -On 4/4/26, staff assisted Tenant C1 with wiping her and felt a "lump in the vaginal area." It was observed by staff that there was a "ball-shaped lump poking out of her vaginal canal." -On 4/10/26, staff changed Tenant C1's brief, she	A 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 282	Continued From page 37	A 282		

was very shaky, her legs were swollen and she had sore on her "bottom."

-On 4/11/26, Tenant C1 refused to get up. Tenant C1 was "soaking wet and sheets were wet too." Staff were in her apartment for an hour and a half.

-On 4/27/26, all scheduled medications were discontinued by hospice.

-On 4/28/26, as needed medications were given around the clock and she was resting in bed.

-On 4/29/26, staff changed and repositioned Tenant C1.

-On 4/30/26, Tenant C1 died.

Continued record review of Tenant C1's file revealed the service plan was updated on 4/17/26 and 4/22/26 for changes in condition; however, the service plan update was not completed until 4/17/26 despite changes as noted above. Additionally, the service plan was not updated after 4/22/26, as needed with the discontinuation of scheduled medications and comfort cares including changing and repositioning.

3. Record review on 5/28/26 and 6/1/26 of Tenant C2's file revealed a discharge date of 5/1/26 and the reason indicated she left to a higher level of care. Observations (nurse's notes) indicated the following:

-On 3/27/26, a nurse was called by staff due to the tenant being unresponsive. Staff were instructed to call 911 and stay with Tenant C2. She was transferred to the hospital. An update was received by family that indicated Tenant C2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 282	Continued From page 38	A 282		

was intubated.

-On 4/9/26, hospital staff reported family was planning to have Tenant C2 discharged to a long-term care facility closer to family and hospice was being considered.

When interviewed on 6/1/26 at 2:00 p.m. Staff E indicated she was not working when Tenant C2 went out to the hospital but around the time it happened Tenant C2 had incontinence issues, was not walking, could not dress herself. She indicated it happened about a month before and was progressive.

When interviewed on 6/1/26 at 3:15 p.m. Staff F explained Tenant C2 needed more assistance with walking, and some toileting. Staff helped with medications and she generally dressed herself. At about 8:00 p.m. another staff called her and Tenant C2 was unresponsive. She was laying flat on her back on her bed, breathing, she would not tilt her head back, and was rigid. The nurse was called and emergency medical services (EMS) were called. Staff had to call Tenant C2's family to figure out her code status, it was not in her apartment.

Continued record review of Tenant C2's file revealed the most recent service plan update was dated 2/28/26. The service plan indicated Tenant C2 was independent with toileting, mobility and transfers and dressing. The service plan was not updated as needed to reflect the change in Tenant C2's condition as noted above.

When interviewed on 6/17/26 at 11:10 a.m. the Clinical and Quality Assurance Specialist confirmed all service plans were provided that were requested for the tenants reviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 293	481-69.27(2)c Nurse Review 481-69.27(231C) Nurse review. 69.27(2) If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete a nurse review as needed related to missed insulin doses and elevated blood glucose levels. This pertained to 1 of 1 current tenant reviewed with missed insulin doses (Tenant #2). Findings follow: Record review on 5/27/26 and 5/28/26 of Tenant #2's file revealed a diagnosis of diabetes mellitus type 2. Observations (nurse's notes) indicated the following: -On 3/5/26, orders were received to discontinue sliding scale insulin and start Tresiba 100 flex touch 100 unit/milliliters (ml), inject 16 units daily and Novolog flex pen inject 2 units, three times per day for blood glucose greater than 150. -On 3/17/26, a call was placed to pharmacy requesting the insulin delivered sooner as Tenant #2's blood glucose was high due to being out of	A 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 293	Continued From page 40	A 293		

insulin. Pharmacy indicated they would send it out as soon as possible.

-On 3/17/26, a call was placed to the primary care provider's (PCP) office regarding Tenant #2's blood glucose levels.

-On 3/17/26, the medication manager on duty notified the nurse Tenant #2's blood glucose was 495 and he did not have any more insulin for the night. The nurse called and spoke to the on-call provider. Due to advanced age and lack of symptoms he did not want to give extra insulin at that time and to call back with any symptoms.

-On 3/18/26, the continuous glucometer sensor was added to the as needed orders.

-On 3/19/26, Tenant #2's blood glucose was 497 and he was asymptomatic. A new order was received to increase Novolog to 6 units three times daily.

Continued record review revealed the March 2026 medication administration records (MARs) reflected the following:

-Tresiba Flex injection 100 unit, inject 16 units, under the skin every day at 8:00 a.m. It reflected a start date of 3/4/26 and was documented as administered from 3/5/26 to 3/11/26. On 3/12/26 it was not documented as administered and from 3/13/26 to 3/17/26 the medication was not documented as administered due to not being available.

Tenant #2's blood glucose readings during that time period and after included the following:

On 3/12/26 at 8:00 a.m. it was 249, at 12:00 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUMMIT OF CORALVILLE	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 293	Continued From page 41 it was 319 and at 5:00 p.m. it was 339 -On 3/13/26 at 5:00 p.m. it was 353 -On 3/14/26 there were no blood glucose readings documented -On 3/15/26 at 5:00 p.m. it was 285 -On 3/16/26 at 4:00 p.m. it was 551 -On 3/17/26 at 7:00 a.m. it was charted as refused, at 11:00 a.m. charted as 564 and 4:00 p.m. charted as 483 -On 3/18/26 at 7:00 a.m. it was 513, at 11:00 a.m. it was 518 and at 4:00 p.m. it was 535 -On 3/19/26 at 4:00 p.m. it was 497 -On 3/23/26 at 7:00 a.m. it was 430, at 11:00 a.m. it was 406 -On 3/25/26 at 7:00 a.m. it was 409 Further record review revealed Observations (nurse's notes) reflected the PCP was contacted regarding Tenant #2's elevated blood glucose levels on 3/17/26 as noted above; however, there were no additional notifications of the PCP related to continued blood glucose levels. Continued record review revealed Tenant #2's file lacked a documented nurse review related to the missed insulin doses and elevated blood glucose levels. Additionally, after the insulin was received and doses were administered as ordered, Tenant #2 continued to have elevated blood glucose levels and a nurse review was not completed.	A 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0383	A. BUILDING: _____ B. WING _____	C 06/17/2026

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

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A 293	Continued From page 42 When interviewed on 6/17/26 at 11:10 a.m. the Clinical and Quality Assurance Specialist confirmed a nurse review was not completed.	A 293		

Tag A000- 231C.16A Medication Setup – Administration and Storage of Medications

The Clinical and QA Specialist and Area Director of Operations and Sales reviewed medication storage practices, controlled substance access, and the Program's medication storage policy. The combination-code locks used for controlled substance storage were removed and replaced with keyed locks. Keys are restricted to authorized onshift associates responsible for medication administration and medication storage. All medication associates and licensed nurses will be re-educated regarding secure medication storage requirements and the expectation that controlled substances remain inaccessible to unauthorized individuals at all times.

The Program will implement the following system-level measures:

Medication storage areas will utilize keyed locking systems with access limited to authorized associates responsible for medication administration or storage.
Controlled substance storage will remain secured in accordance with Program policy and applicable regulatory requirements.
Medication associates will be educated regarding key control and prohibited sharing of medication-storage access with unauthorized individuals.
Any identified concern involving medication storage or unauthorized access will be addressed immediately through re-education, counseling, competency validation, or other corrective action as appropriate.

The Executive Director, Program Nurse, or designee will monitor compliance as follows:

Medication storage and controlled substance access will be audited weekly.

Audits will verify that medications remain secured, keyed locks are functioning properly, and access is limited to authorized medication associates.
Any identified noncompliance will result in immediate corrective action and additional monitoring.

The Program will achieve substantial compliance by **September 18, 2026**.

The Executive Director and Program Nurse (or designee) are responsible for implementation and ongoing oversight of this Plan of Correction.

Tag A116 – 481-67.2(2) Program Policies and Procedures

The Clinical and Quality Assurance Specialist and AWD reviewed the Program's policies and procedures related to controlled substances, advance directives, and incident reporting. Tenant records identified in the survey will be reviewed and corrected as applicable. Community associates and agency staff will be re-educated on following established Program policies and procedures, including complete documentation, timely reporting, and required follow-up.

The Program will implement the following system-level measures:

Controlled substance discrepancies will be investigated immediately in accordance with Program policy. Any required adjustment will include a detailed explanation, appropriate incident documentation, and notification to the Program Nurse or designee.

Tenant records will be reviewed at move-in to verify completion of advance directive acknowledgement documentation and receipt or documented request for applicable advance directive or DNR documentation (IPOST).

Incident reports will be completed in accordance with Program policy and include required information, including vital signs, witness information, identification of the associate completing the report, and required nursing or leadership follow-up.

Community associates and agency staff responsible for medication administration, admission documentation, or incident reporting will receive education regarding applicable Program policies and documentation requirements.

The Executive Director, Program Nurse, or designee will monitor compliance as follows:

Controlled substance discrepancy documentation will be reviewed with each identified discrepancy immediately upon occurrence.

All current resident records will be audited by September 25, 2026, and new move-in records will be audited at time of move-in to verify required advance directive documentation is complete and receipt or documented request for applicable advance directive or DNR documentation (IPOST) is present.

Incident reports will be reviewed within 3 business days of incident for completeness and compliance with Program policy.

Any identified noncompliance will result in immediate correction, re-education, competency validation, or other corrective action as appropriate.

The Program will achieve substantial compliance by **September 25, 2026**.

The Executive Director and Program Nurse (or designee) are responsible for implementation and ongoing oversight of this Plan of Correction.

Tag A122 – 481-67.3(2) Tenant Rights

The Clinical and Quality Assurance Specialist and Program Nurse reviewed the findings related to Tenant C2. Tenant C2 is no longer residing at the community.

The Program will implement the following corrective measures to prevent recurrence:

All tenants will receive services based on current, accurate assessments of their functional, medical, cognitive, and psychosocial needs.

Staff will be educated that changes in a tenant's condition must be reported promptly to the Program Nurse or designee and documented in the tenant record. The nurse or designee will evaluate the change, determine whether additional services or monitoring are needed, notify the appropriate representative and healthcare provider, and update the assessment and service plan within 7 days per policy.

The Program will establish a process for follow-up when a tenant does not attend a scheduled meal or when there is another indication that the tenant may not be receiving expected services. Staff will document the follow-up, including contact with the tenant, observation of the tenant's condition, notification of the nurse or designee, and any interventions provided. If the tenant cannot be located or is found with a change in condition, staff will follow emergency response procedures immediately.

Tenants who decline routine well checks will have their preferences documented in the service plan. Staff will continue to honor tenant rights while implementing an individualized safety and monitoring plan, including the frequency and method of attempted contact, circumstances requiring escalation, and notification of the tenant's representative or healthcare provider when appropriate.

Staff will be re-educated on recognizing and reporting changes in condition, responding to an unresponsive tenant, calling emergency medical services, remaining with the tenant, obtaining vital signs when appropriate, documenting the event, and notifying the nurse, leadership, family, legal representative, and healthcare provider in accordance with Program policy.

Advance directive and code status information will be verified at move-in, upon return from hospitalization, and whenever there is a significant change in condition. Documentation will be maintained in the tenant's record. If documentation is unavailable, staff will follow the applicable emergency response and notification procedures and will not delay calling 911.

Medication administration records will be reviewed for completeness and accuracy. Missed, refused, or delayed medications, will be reported promptly to the Program Nurse or designee, documented, and addressed according to the medication management policy.

The Program Nurse, or designee will monitor compliance as follows:

All current tenants' assessments and service plans will be completed per policy and with change in condition to verify that identified care needs are accurately reflected and that required services and monitoring are documented.

Advance directives/code status records will be audited for all residents in AL and MC. Any code statuses missing from electronic record will be verified and entered.

Medication administration records and documentation of missed or refused medications will be audited routinely.

Any identified noncompliance will be corrected immediately. Staff will receive re-education and competency validation when indicated, and additional corrective action will be taken as appropriate.

The Program will achieve substantial compliance by **September 25, 2026**.

The Program Nurse or designee is responsible for implementation, monitoring, and ongoing oversight of this Plan of Correction.

Tag A152 – 481-67.5(2)e(3) Medications

The Clinical and Quality Assurance Specialist and Program Nurse reviewed the Program's medication administration practices, medication availability, medication administration records, provider orders, blood glucose monitoring, PRN effectiveness documentation, and treatment administration. Tenant records identified in the survey will be reviewed and corrected as applicable. Community associates and agency staff responsible for medication administration will be re-educated regarding administering medications and treatments exactly as ordered, timely medication availability, accurate eMAR documentation, and required follow-up for missed, unavailable, refused, or PRN medications.

The Program will implement the following system-level measures:

Medication orders will be reviewed against the eMAR to verify that medication name, dose, frequency, treatment instructions, and start and stop dates accurately reflect current provider orders.

Med Managers will verify medication availability and report medications that are unavailable before a scheduled dose is missed. The pharmacy, Program Nurse or designee, and provider will be notified as appropriate to obtain the medication or further direction.

Missed, unavailable, refused, delayed, or omitted medications and treatments will be documented and reported to the Program Nurse or designee for appropriate follow-up.

Blood glucose monitoring and insulin administration will be completed in accordance with current provider orders, and abnormal findings will be reported and addressed according to orders.

PRN medication effectiveness will be documented within the required timeframe following administration.

Medications with specific administration schedules, treatment cycles/dates, pre-medication requirements, or other special instructions will be reviewed carefully and administered according to the provider order.

The Program Nurse or designee will monitor compliance as follows:

MARs and current provider orders will be audited 2 days per week for four weeks and weekly thereafter to verify medications and treatments are administered as ordered.

Medication availability will be audited 3 days per week for four weeks and weekly thereafter, including follow-up on medications documented as unavailable.

PRN medication documentation, blood glucose monitoring, insulin administration, and medications with special administration instructions will be audited weekly for four weeks and monthly thereafter.

Any identified noncompliance will result in immediate correction, re-education, competency validation, provider or pharmacy notification when appropriate, and additional monitoring.

The Program will achieve substantial compliance by **September 18, 2026**.

The Program Nurse or designee are responsible for implementation and ongoing oversight of this Plan of Correction.

Tag A191 – 481-67.9(1) Staffing

The Clinical/Quality Assurance Nurse and Program Nurse reviewed staffing levels, tenant service needs, care assignments, pendant response times, medication administration practices, and completion of scheduled tenant services. Leadership will review staffing coverage weekly and utilize available PRN staff, overtime, leadership support, and/or qualified agency staff when additional coverage is necessary. All community associates and agency staff will be re-educated regarding timely completion and accurate documentation of assigned tenant services. Staff may only document a service after it has been completed. All staff will also be re-educated regarding prompt response to tenant pendants and the need to prioritize urgent requests, including toileting and nursing needs. The Program Nurse or designee will review medication administration practices and investigate any allegation or discrepancy involving medications documented as administered but not actually given. Medication staff competency will be verified as appropriate.

The Program will implement the following system-level measures:

- Weekly review of staffing coverage and tenant care needs.
- Orientation and oversight of agency staff consistent with Program expectations.
- Routine review of care documentation for missed, late, or inaccurate entries.
- Routine review of pendant response reports for excessive delays or trends.
- Ongoing medication administration oversight by the Program Nurse or designee.
- Immediate re-education, counseling, competency validation, or other corrective action when concerns are identified.

The Executive Director, Program Nurse or designee will monitor compliance as follows:

- Staffing coverage will be reviewed weekly
- Care/task documentation, including showers, linen changes, toileting, and other scheduled services, will be audited 3 days per week for four weeks and weekly thereafter.
- Pendant response reports will be reviewed twice weekly for 30 days and routinely thereafter.
- Medication administration and documentation will be audited weekly for four weeks and monthly thereafter.

Any identified noncompliance will result in immediate corrective action and additional monitoring. The Program will achieve substantial compliance by September 20, 2026. The Executive Director and Program Nurse are responsible for implementation and ongoing oversight of this Plan of Correction.

Tag A 193- 481-67.9(3) Staffing – Documentation

The Clinical and Quality Assurance Specialist reviewed the Program's staffing-agency documentation process. The Program will obtain and maintain required documentation for all agency staff before they begin working at the Program, including verification of completed background checks, hiring materials, training records, and nurse-delegation training documentation when applicable. The Program will also maintain current staffing schedules and documentation of all training received by program staff, including certified and noncertified staff trained in nurse-delegated procedures.

The Program will implement the following system-level measures:

All agency staff files will include documentation verifying that required background checks were completed by the staffing agency before the staff member works at the Program.

The Program will obtain and maintain documentation of nurse-delegated procedure training for all community and agency staff who perform nurse-delegated procedures.

The Program will maintain training records for certified and noncertified staff, including the date of training, subject matter, trainer, staff member's name, and staff member's signature or other verification of completion.

The Program will maintain current staffing schedules and agency staffing records to verify which staff members worked at the Program and whether required documentation was completed before assignment.

The Program will not permit agency staff to work independently or perform nurse-delegated procedures until required background-check verification and applicable training documentation have been received and reviewed.

The Executive Director, Program Nurse, or designee will monitor compliance as follows:

All agency staff files will be reviewed before the staff member's first scheduled shift.

The review will verify that background-check documentation, hiring materials, applicable nurse-delegation training records, and other required training documentation are present and current.

Any missing or incomplete documentation will be corrected immediately. Staff members without required documentation will not be scheduled to work until compliance is verified.

The Program will achieve substantial compliance by **September 25, 2026**.

The Executive Director, Program Nurse (or designee) are responsible for implementation and ongoing oversight of this Plan of Correction.

Tag A198 – 481-67.9(4)(d) Staffing – Nurse Delegation

The Clinical and Quality Assurance Specialist and Program Nurse reviewed the Program's nurse-delegation process for community associates and agency staff. The New Program Nurse will ensure all applicable community associates and agency staff receive required nurse-delegation training applicable to the service-plan tasks they perform. Training will address medical and nursing directives, tenant-specific service-plan tasks, and the health, cognitive, and functional needs of tenants. Community associates and agency staff will not independently perform nurse-delegated tasks until required training and competency have been completed and documented.

The Program will implement the following system-level measures:

All applicable community associates and agency staff will receive nurse-delegation training prior to independently performing delegated service-plan tasks.

The Program Nurse or designee will verify competency and maintain documentation of completed nurse-delegation training.

New or revised nurse-delegated tasks will be reviewed with appropriate community associates and agency staff when tenant needs, medical directives, or service plans change.

The Program Nurse or designee will monitor compliance as follows:

Community associate and agency staff training records will be reviewed before the staff member independently performs nurse-delegated tasks.

Training records will be audited at beginning of employment and routinely thereafter to verify required nurse-delegation training and competency documentation are complete.

Any identified noncompliance will result in immediate correction, re-education, competency validation, and restriction from nurse-delegated tasks until compliance is verified.

The Program will achieve substantial compliance by **September 25, 2026**.

Tag A232 – 481-69.22(3) Evaluation of Tenant

The Clinical and Quality Assurance Specialist and Program Nurse reviewed the Program's policy for completing tenant evaluations with significant changes in condition. The records of Tenant #3, Tenant C1, and Tenant C2 were reviewed, and corrective action will be completed as applicable. Community associates and agency staff will be re-educated on promptly reporting changes in a tenant's functional, cognitive, or health status to the Program Nurse or designee.

The Program will implement the following system-level measures:

The Program Nurse or designee will complete or coordinate an updated tenant evaluation when a significant change in condition is identified, including changes in mobility, transfers, continence, behavior, cognition, ability to complete activities of daily living, medication needs, skin condition, hospice or comfort-care status, or other health concerns.

Service plans will be reviewed and updated as indicated following a significant change evaluation to ensure current tenant needs and required services are accurately reflected.

Community associates and agency staff will be educated to immediately report changes in condition, repeated care refusals, increased assistance needs, changes in continence, new behaviors, falls, abnormal findings, or other significant changes to the Program Nurse or designee.

The Program Nurse or designee will review nursing notes, incident reports, hospital transfers, provider communications, and other documentation for changes that may require reassessment.

The Program Nurse or designee will monitor compliance as follows:

Current tenant records will be audited to verify annual evaluations are current and identify significant changes have resulted in appropriate reassessment and service-plan review.

Change-in-condition documentation (including hospital transfers, hospice admissions, significant changes in functional status, and repeated care refusals) will be audited routinely and Change in Condition evaluations will be completed within 7 days per policy.

Any identified noncompliance will result in immediate correction, re-education, competency validation, and additional monitoring as appropriate.

The Program will achieve substantial compliance by **September 18, 2026**.

The Program Nurse or designee are responsible for implementation and ongoing oversight of this Plan of Correction.

Tag A268 – 481-69.25(1)(i) Tenant Documents

The Clinical and Quality Assurance Specialist and Program Nurse reviewed the Program's process for nursing documentation by exception. The records of tenants requested were reviewed, and corrective action will be completed as applicable. Associates will be re-educated regarding timely and complete documentation of significant changes in condition, abnormal findings, hospital transfers, provider communication, follow-up, monitoring, and discharge.

The Program will implement the following system-level measures:

Nursing notes will be completed when there is a significant change in a tenant's condition, abnormal assessment finding, change in continence, care refusal affecting health or safety, diagnostic testing, provider notification, hospital transfer, return from hospitalization, or other event requiring nursing follow-up.

The Program Nurse or designee will ensure abnormal test results and provider communications include documentation of follow-up, interventions, monitoring instructions, and any resulting changes to the tenant's plan of care.

Hospital transfers and discharges from the Program will include appropriate nursing documentation summarizing the event, disposition, and required follow-up.

Associates will be re-educated on documentation-by-exception requirements and the expectation that nursing documentation accurately reflects assessment, intervention, communication, and follow-up.

The Program Nurse or designee will monitor compliance as follows:

Nursing notes will be reviewed routinely to verify significant changes and required follow-up are appropriately documented.

Hospital transfers, diagnostic results, provider notifications, and tenant discharges will be reviewed routinely for complete nursing documentation.

Any identified noncompliance will result in immediate correction, re-education, competency validation, and additional monitoring as appropriate.

The Program will achieve substantial compliance by **September 18, 2026**.

The Program Nurse or designee are responsible for implementation and ongoing oversight of this Plan of Correction.

Tag A274 – 481-69.25(1)(o) Tenant Documents – Incident Reports

The Clinical and Quality Assurance Specialist and Program Nurse reviewed the Program's incident reporting process related to medication errors. Records were reviewed, and corrective action will be completed as applicable. Community associates and agency staff responsible for medication administration will be re-educated regarding the requirement to complete an incident report for medication errors, including missed doses, unavailable medications, incorrect administration, and failure to follow medication-specific administration instructions.

The Program will implement the following system-level measures:

Incident reports will be completed for medication errors in accordance with Program policy, including missed, omitted, delayed, unavailable, or incorrectly administered medications.

Community associates and agency staff responsible for medication administration will immediately report identified medication errors to the Program Nurse or designee and complete required incident documentation.

The Program Nurse or designee will review medication errors for appropriate tenant assessment, provider and responsible-party notification when indicated, follow-up interventions, and completion of incident documentation.

Medication administration records will be reviewed for missed, unavailable, refused, or incorrectly administered medications to identify situations requiring an incident report.

The Program Nurse or designee will monitor compliance as follows:

Medication administration records and incident reports will be audited routinely to verify medication errors are identified and appropriately reported.

All identified medication errors will be reviewed for completion of required incident documentation and appropriate follow-up.

Any identified noncompliance will result in immediate correction, re-education, competency validation, and additional monitoring as appropriate.

The Program will achieve substantial compliance by **September 18, 2026.**

The Program Nurse or designee are responsible for implementation and ongoing oversight of this Plan of Correction.

Tag A280 – 481-69.26(1) Service Plans

The Clinical and Quality Assurance Specialist and Program Nurse reviewed the Program's service-plan process and policy. The service plans for Tenant #2 and Tenant #4 were reviewed and will be updated as applicable to accurately reflect current identified needs, including diabetes management, continuous glucose monitoring, medication administration, and medication refusals. Community associates and agency staff will be re-educated regarding the requirement to report changes in tenant needs and recurring care concerns to the Program Nurse or designee for service-plan review and revision.

The Program will implement the following system-level measures:

Service plans will be developed and updated based on current tenant evaluations and will accurately reflect the services being provided to meet each tenant's identified needs.

Changes in medication management, glucose monitoring, use of medical devices, recurring medication refusals, changes in functional status, or other changes in care needs will be reported to the Program Nurse or designee and incorporated into the service plan when indicated.

The Program Nurse or designee will review significant changes, recurring care patterns, provider orders, medication records, and nursing documentation to determine whether the service plan requires revision.

Community associates and agency staff will be educated to promptly communicate changes in tenant needs, refusals, or care practices that may require service-plan updates.

The Program Nurse or designee will monitor compliance as follows:

Current tenant service plans will be reviewed to verify identified care needs and services are accurately reflected.

Service plans will be reviewed per scheduled due date or upon notification of change to reflect accurate cares are being provided.

Medication records, nursing notes, and change-in-condition documentation will be compared with service plans routinely to identify any needed revisions.

Any identified noncompliance will result in immediate correction, service-plan revision, re-education, and additional monitoring as appropriate.

The Program will achieve substantial compliance by **September 18, 2026.**

The Program Nurse or designee are responsible for implementation and ongoing oversight of this Plan of Correction.

Tag A282 – 481-69.26(3) Service Plans

The Clinical and Quality Assurance Specialist and Program Nurse reviewed the Program's policy for updating service plans following significant changes in condition. The records of Tenant #3, Tenant C1, and Tenant C2 were reviewed, and corrective action will be completed as applicable. Community associates and agency staff will be re-educated regarding prompt reporting of changes in a tenant's health, cognitive, functional, behavioral, continence, mobility, medication, or personal care needs to the Program Nurse or designee.

The Program will implement the following system-level measures:

Service plans will be updated as needed following a significant change in condition and will accurately reflect the tenant's current needs and services being provided.

Changes including increased incontinence, repeated care refusals, changes in mobility or transfers, increased assistance with dressing or toileting, behavior changes, skin concerns, hospice or comfort-care needs, and medication changes will be reviewed for service-plan revision.

The Program Nurse or designee will review significant changes, nursing documentation, hospital transfers, hospice enrollment, provider orders, and changes in tenant assistance needs to determine whether the service plan requires updating.

Community associates and agency staff will be educated to promptly report changes in tenant condition and increased care needs so the Program Nurse or designee can evaluate the need for service-plan revision.

The Program Nurse or designee will monitor compliance as follows:

Current tenant service plans will be audited to verify identified needs and current services are accurately reflected.

Significant changes in condition (hospital transfers, hospice admissions, medication changes, increased assistance needs, repeated care refusals, and other significant changes) and related service-plan updates will be audited routinely and services plans updated per policy.

Any identified noncompliance will result in immediate correction, service-plan revision, re-education, and additional monitoring as appropriate.

The Program will achieve substantial compliance by **September 18, 2026.**

The Program Nurse or designee are responsible for implementation and ongoing oversight of this Plan of Correction.

Tag A293 – 481-69.27(2)(c) Nurse Review

The Clinical and Quality Assurance Specialist and Program Nurse reviewed the Program's nurse-review process related to changes in tenant health status. Tenant #2's record was reviewed, including missed insulin doses, elevated blood glucose readings, provider notifications, medication availability, and follow-up. Corrective action will be completed going forward. Community associates and agency staff will be re-educated regarding prompt reporting of abnormal findings, missed medications, and changes in tenant condition to the Program Nurse or designee.

The Program will implement the following system-level measures:

The Program Nurse or designee will complete and document a nurse review whenever there is a significant change (or at the required 90 days, if no changes are noted) in a tenant's health status, including persistent abnormal blood glucose readings, missed insulin doses, medication unavailability, or other findings requiring nursing assessment and follow-up.

Abnormal findings will be assessed and documented, with provider notification, recommendations, referrals, interventions, and ongoing monitoring completed as appropriate.

Medication associates will immediately report missed insulin doses, unavailable medications, and abnormal blood glucose readings to the Program Nurse or designee.

The Program Nurse or designee will monitor progress following recommendations or changes in treatment and document continued follow-up until the concern is resolved or stabilized.

The Program Nurse or designee will monitor compliance as follows:

Nurse reviews related to changes in condition will be audited routinely and completed as scheduled or as needed for change in condition.

Blood glucose records, missed medication documentation, provider notifications, and nursing notes will be reviewed routinely to verify appropriate nursing assessment and follow-up were completed.

Any identified noncompliance will result in immediate correction, re-education, competency validation, and additional monitoring as appropriate.

The Program will achieve substantial compliance by **September 18, 2026**.

The Program Nurse or designee are responsible for implementation and ongoing oversight of this Plan of Correction.

A309 – 481-67.18(3)b – Background Checks

Deficiency: The Program failed to ensure required background checks were completed and approved before agency staff worked in the community.

1. Corrective Action:

The files of the four agency staff identified during the survey will be reviewed to verify required background checks and approvals are complete. Any individual without required clearance will not work until verification is completed.

2. Identification of Others Potentially Affected:

All current employee and agency staff files will be reviewed to verify required background checks were completed before the individual began working. Any missing or incomplete documentation will be corrected immediately.

3. Systemic Change:

Effective immediately, no employee or agency staff member will be permitted to work until required background checks and approvals are completed and verified. The Business Office Manager or designee will maintain verification documentation before staff are placed on the schedule.

4. Monitoring:

The Executive Director or designee will audit new employee and agency staff files weekly for four weeks and monthly for three months. Any identified noncompliance will be corrected immediately and additional education provided as needed.

5. Responsible Person:

Executive Director and Business Office Manager or designee.

A227 – 481-69.21(3) – Occupancy Agreement

Deficiency: The Program failed to update the occupancy agreement to reflect a change in services related to the Program no longer providing sliding-scale insulin.

1. Corrective Action:

The identified tenant's occupancy agreement will be reviewed and updated to accurately reflect the services provided by the Program, including applicable medication-service limitations.

2. Identification of Others Potentially Affected:

Current occupancy agreements will be reviewed to identify tenants whose services or financial arrangements have changed without an appropriate update. Any discrepancies identified will be corrected.

3. Systemic Change:

Occupancy agreements will be reviewed whenever there is a change in services or financial arrangements. Changes will be communicated to the tenant and/or legal representative and documented in the occupancy agreement or appropriate written amendment.

4. Monitoring:

The Executive Director or designee will audit applicable occupancy agreements weekly for four weeks and monthly for three months to ensure agreements accurately reflect current services. Any discrepancy will be corrected promptly.

5. Responsible Person:

Executive Director or designee.