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
	16427_hfd	A. BUILDING: _____ B. WING _____	C 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 13 Tenants with cognitive impairment: 24 Total census: 37 The following regulatory insufficiencies were cited during the investigation of Incident #131030-I:	A 000	see attached POC 6/22/26	
A 116	481-67.2(2) Program Policies and Procedures 67.2(2) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow established policy and procedure related to incident reports. This pertained to 1 of 1 tenant file reviewed (Tenant #1). Findings follow: 1. Record review on 5/12/26 and 5/13/26 of Tenant #1's file revealed an Incident Report documented on 12/15/25 at 6:30 a.m. third shift staff found Tenant #1 with an injury of unknown origin. The incident occurred in Tenant #1's apartment. The Wellness Director was notified by staff that Tenant #1 had a black eye. Staff reported Tenant #1 did not have a black eye at the end of second shift and she had to have bumped in on something in her sleep. There were no fall reports that night for Tenant #1. Tenant #1 had bruising and swelling below both eyes and to her nose. No treatment was	A 116		

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A 116	Continued From page 1	A 116		

provided, Tenant #1 was not sent out to the emergency department (ED), the primary care provider (PCP) was not notified and vital signs were not recorded. Tenant #1's legal representative was notified on 12/15/25 at 10:37 a.m.

2. Continued record review revealed an Internal Occurrence Investigation Report dated 12/17/25 indicated on 12/15/25 at 6:30 a.m. Tenant #1 was awakened for the day and staff noticed bruising under her left eye. No injuries or falls had occurred. Tenant #1's legal representative was spoken to in person when visited at lunch time. The cause was unknown and staff reported safety rounds were completed. No concerns of abuse or neglect were noted.

3. Further record review on 5/13/26 of the Program's policy and procedure related to Incident Reports indicated injuries and unusual incidents would be reported. An Internal Occurrence Investigation Report was completed by staff or all unusual occurrences, injuries of unknown origin and incidents. An Incident Report was documented in the electronic health record. Incidents were "immediately" reported to the tenant's family and primary care provider (PCP). The date and time of the report to the family would be documented in the narrative charting in the tenant record and on the incident report under notifications.

4. Continued record review of Tenant #1's file revealed she sustained an injury of an unknown origin, which was observed on 12/15/25 at 6:30 a.m. Tenant #1's PCP was not notified of the incident per policy and procedure. Additionally, Tenant #1's legal representative was notified on 12/15/25 at 10:37 a.m.; however, was not notified

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A 116	Continued From page 2 immediately per policy and procedure. 5. When interviewed on 5/14/26 at 10:20 a.m. the Wellness Director confirmed there was no documentation that indicated Tenant #1's PCP was notified. She said they wanted to talk to staff before contacting Tenant #1's legal representative.	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 care, treatment and services that were adequate and appropriate. This pertained to 1 of 1 tenant reviewed (Tenant #1). Findings follow: 1. Record review on 5/12/26 and 5/13/26 of Tenant #1's file revealed an Incident Report indicated on 12/15/25 at 6:30 a.m. third shift staff found Tenant #1 with an injury of unknown origin. The incident occurred in Tenant #1's apartment. The Wellness Director was notified by staff that Tenant #1 had a black eye. Staff reported Tenant #1 did not have the black eye at the end of second shift and she had to have bumped in on something in her sleep. There were no fall reports that night for Tenant #1. Tenant #1 had bruising and swelling below both eyes and to her nose. No treatment provided, Tenant #1 was not sent out to the emergency department (ED), the	A 122		

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A 122	Continued From page 3	A 122		

primary care provider (PCP) was not notified and vital signs were not recorded. Tenant #1's legal representative was notified on 12/15/25 at 10:37 a.m.

Continued record review revealed an Internal Occurrence Investigation Report dated 12/17/25 indicated on 12/15/25 at 6:30 a.m. it was noted Tenant #1 was awakened for the day and staff noticed bruising under her left eye. No injuries or falls had occurred. Tenant #1's legal representative was spoken to in person when visited at lunch time. The cause was unknown and staff reported safety rounds were completed. No concerns of abuse or neglect were noted.

2. When interviewed on 5/13/26 at 2:33 p.m. Staff A said she worked second shift (day prior to the discovery of the injury). She assisted Tenant #1 with bedtime medications and cares. Tenant #1 went to bed that night and stayed in bed. There were no injuries to Tenant #1's face noted on Staff A's shift. At 11:00 p.m. the last round was completed with third shift staff and Tenant #1 was asleep. Staff A said the next day she noted purple discoloration under Tenant #1's eyes and Tenant #1 was not like that when Staff A left the day prior.

When interviewed on 5/14/26 at 9:42 a.m. Staff B said she worked on third shift that night with Staff C and Staff D. She was called into Tenant #1's apartment by staff and Tenant #1's black eye was discovered before first shift and it had just started forming. Tenant #1 was asleep in bed and staff went to get her ready for the day. Staff B said the other staff assisted with Tenant #1's two-hour checks, she did not assist.

Record review revealed Staff B's Incident

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Witness Statement noted she completed the last rounds and Tenant #1's walker was in bathroom doorway and her blankets were off. She was hanging off of the bed slightly. Staff noticed her eye was swollen and black. The Wellness Director was notified.

When interviewed on 5/14/26 at 8:15 a.m. Staff C said she worked on third shift. There was a medication aide and two caregivers. She said staff never completed rounds alone and were always together. She observed Tenant #1's eye at the 5:00 a.m./6:00 a.m. round and it was blue/purple and was forming, it was starting to develop. Rounds were completed with a small flashlight. When the 5:00 a.m./6:00 a.m. round was completed the light was turned on, staff were getting Tenant #1 up for the day and noticed there was something going on with her eye. It was documented and the nurse was called. She could not recall where the walker was located and said it had been months since she worked there. She said whatever she wrote down was where it was.

Record review revealed Staff C's Incident Witness Statement indicated she was passing medications and heard the caregivers concern and was called to her apartment. When Staff C walked in, she noticed Tenant #1's eye was light purple, blue and it was still forming. Caregivers were also on the phone with the Wellness Director to let her know what happened. It was noted Tenant #1's walker was taken away from her when she was put to bed.

When interviewed on 5/14/26 at 4:38 p.m. Staff D said she worked third shift and there were three staff on that shift, one medication passer and two caregivers. She worked with Staff B and Staff C.

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A 122	Continued From page 5	A 122		

She said Tenant #1 had urinary incontinence and had checks when staff first got there and then her undergarment was checked at 1:00 a.m., 3:00 a.m. and 5:00 a.m. When asked if the checks were done, Staff D said she thought so, Tenant #1 was considered a "heavy wetter." She said there were people that were more of a priority. She was checked if dry or if a line was present (on the undergarment). If she did not want to get up to toilet she did not have to go. She said staff encouraged three times. She said Tenant #1 was left alone if there was no line on her undergarment and she was not disturbed unless necessary. A flash light on the phone was used for checks at night. When completing the last round to get Tenant #1 up, the light was turned on and the injury was noted. It looked fresh and Staff D said she knew it was not on her shift. It was not noticed until that time. It as purple and dark and she had her eyeglasses on. Usually, staff did not let tenants sleep in their glasses. She said the walker was usually left near by the door as staff did not want her to get up and fall. The injury was reported to the nurse.

3. Record review revealed Tenant #1's December 2025 task administration record (TAR) reflected tasks including: continence management full assistance, safety checks twice at night (12:00 a.m. and 3:00 a.m.), dressing, incontinence check every two hours at night (1:00 a.m., 3:00 a.m., 5:00 a.m. and 11:00 p.m.), personal hygiene, oral cares, eye sight (wake up and bed time), eating, routine safety checks every two hours at night and bating (twice per week).

Continued record review reflected the December 2025 TAR indicated on 12/14/25 continence management was documented as completed at 9:29 p.m. (7:00 p.m. task) and was not signed off

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A 122	Continued From page 6	A 122		

as completed at 10:00 p.m. Dressing was signed off as completed on 12/14/25 at 9:30 p.m. (8:00 p.m. task). Oral cares and eyesight assistance were signed off as completed at 9:30 p.m. The TAR indicated on 12/15/25 the incontinence checks every two hours at night at was not documented as completed at 1:00 a.m., 3:00 a.m. or 5:00 a.m. The 11:00 p.m. check on 12/14/25 was also not documented as completed. The routine safety checks every two hours at night at 1:00 a.m., 3:00 a.m. at 5:00 a.m. were not documented as completed. The 11:00 p.m. check on 12/14/25 was also not documented as completed.

Further record review revealed Tenant #1's December 2025 TAR reflected tasks were not documented included in shifts prior to the discovery of Tenant #1's injury of unknown etiology. Additionally, January 2026 to May 2026 TARs reflected tasks not signed off as completed or tasks not signed off at the times listed on the TAR.

4. When interviewed on 5/14/26 at 10:20 a.m. the Wellness Director said on 12/15/26 at 6:30 a.m. staff called and said Tenant #1 was checked on at a safety/incontinent check and had a left black eye. Staff sent a picture of the injury. She said Tenant #1 was an early riser and was on the third shift to get up. She started an investigation and interviewed staff. Staff did not verbally say if they had completed the checks. She confirmed there were no checks documented as completed at 1:00 a.m., 3:00 a.m. and 5:00 a.m. The last one was at 9:00 (p.m.). She said Tenant #1 would not be able to get herself up off the floor and she did not think she would be able to get herself out of bed. She talked with staff to ensure they were documenting what they were doing and

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A 122	Continued From page 7 when they were doing it. To prove when cares were provided. She said there were no falls, no evidence of tenant to tenant aggression or concerns with abuse or neglect.	A 122		
A 268	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 1 of 1 tenant file reviewed (Tenant #1). Findings follow: 1. Record review on 5/13/26 of Tenant #1's file revealed Observations (nurse's notes) indicated the following: -On 1/26/26 it was noted an incident report was completed for an unwitnessed fall. -On 1/27/26 it was noted Tenant #1's legal representative reported the emergency department (ED) found a third skin tear on her left upper arm. All three skin tears were dressed and	A 268		

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A 268	Continued From page 8 none required sutures. At the ED Tenant #1 was tested for a urinary tract infection (UTI) and it was positive. She was admitted to the hospital for intravenous (IV) antibiotics and would be there for a couple of days. -On 1/29/26 it was noted Tenant #1 returned from the hospital, wound care orders were entered, she would receive a therapy evaluation and had antibiotics for two more days. -On 1/29/26 it was noted the antibiotic was received from pharmacy, she would receive one with dinner and one at bed time. -On 4/6/26 it was noted Tenant #1's legal representative took her to urgent care for a cough and congestion. A new order was received for a doxycycline (antibiotic), take twice daily for seven days and Coricidin HBP for cough. Continued record reviewed revealed nurse's notes were not completed when Tenant #1 went to the ED on 1/27/26, with the completion of the antibiotics upon her return for the treatment of the UTI and to ensure there were no further signs/symptoms of infection. Additionally, another antibiotic was ordered on 4/6/26 related to a cough and congestion and a note was not completed with the completion of the antibiotic and to ensure the respiratory symptoms had resolved. 2. When interviewed on 5/14/26 at 10:20 a.m. the Wellness Director confirmed the above finding.	A 268		
A 274	481-69.25(1)o Tenant Documents	A 274		

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A 274	Continued From page 9 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports need not be included in the tenant's medical record); This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document incident reports as required. This pertained to 1 of 1 tenant file reviewed (Tenant #1). Findings follow: 1. Record review on 5/13/26 of Tenant #1's file revealed Observations (nurse's notes) indicated the following: -On 1/2/26 it was noted Tenant #1 was seated in the hallway on a chair with her right elbow "leaking blood." Staff cleansed the wound with soap and water, dressed it with non-adherent pad and wrapped it with gauze. -On 1/10/26 it was noted staff assisted Tenant #1 to the bathroom and noted a long bruise on her right thigh. Tenant #1 did not have any complaints of pain. Continued record review revealed incident reports were not completed related to the two injuries of unknown origin noted above. 2. When interviewed on 5/14/26 at 10:20 a.m.	A 274		

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A 274	Continued From page 10 the Wellness Director confirmed the above finding.	A 274		
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 develop service plans as needed with significant change and annually. This pertained to 1 of 1 tenant reviewed (Tenant #1). Findings follow: 1. Record review on 5/13/26 of Tenant #1's file revealed evaluations were completed on 11/29/25 and it was noted as completed for annual evaluations. An Assess Needs Annual Assessment was completed on 11/29/25. It was electronically signed by Tenant #1's legal representative on 12/26/25. 2. Continued record review revealed evaluations were completed on 1/29/26 and it was noted as completed for a change of condition (return from hospitalization). An Assess Needs Change of Condition Assessment was completed on 1/29/26. It was electronically signed by Tenant #1's legal representative on 2/18/26.	A 282		

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A 282	Continued From page 11 3. Further record review revealed evaluations were completed (paper and electronic) on 11/29/25 and 1/29/26. The electronic Assess Need Assessments were signed by Tenant #1's legal representative; however, was an evaluation. A separate service plan was not provided for the annual and change of condition. 4. When interviewed on 5/14/26 at 10:20 a.m. the Wellness Director said it had the same information and it was how it was printed (regarding the service plans).	A 282		
A 421	481-69.39(1) Respite Care Services 481-69.39(231C) Respite care services. "Respite care services" means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person, or on request of the tenant as a trial of the program. An assisted living program that chooses to provide respite care services must meet the following requirements related to respite care services and be certified as an assisted living program. 69.39(1) Length of stay. Respite care services will be provided for no more than 30 consecutive days and for a total of no more than 60 days in a consecutive 12-month period beginning on the first day the individual stays in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure the provision of respite	A 421		

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care services did not exceed the allowable length of stay. This pertained to 2 of 2 non-permanent tenants reviewed (Tenant #2 and Tenant #3). Findings follow:

1. When interviewed on 5/13/26 at approximately 12:20 p.m. to 12:30 p.m. the Wellness Director said when asked about current high occupancy, that there were two "day stayers." She said they were not respite tenants and were not in the electronic medical record system.

2. When interviewed on 5/13/26 at 1:49 p.m. the Senior Regional Director of Operations said day stay was not new and it was not respite. An email from her received on 5/13/26 at 1:52 p.m. indicated the two day stay persons signed enrollment papers, Tenant #2 was there Tuesdays and Thursdays. The email indicated Tenant #3 received bathing each day he was there (Monday, Wednesday and Friday). On 5/11/26 Tenant #3 started taking a lorazepam at noon and no other medications were administered for either tenant. She indicated they were neither respite or permanent tenants and were classified as day stay.

3. Record review on 5/13/26 of Tenant 2's documents revealed he had a Day Stay Assessment and Service Plan form completed on 2/19/26. The start of day stay was 2/19/26, days attending were Tuesdays and Thursdays. It indicated he required 24-hour supervision, did not receive any medications while there and had two-hour checks. It was completed by the Wellness Director on 2/19/26. He was staged at four on the Global Deterioration Scale, which indicate moderate cognitive decline. A Morse Fall Scale was also completed on 2/19/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16427_hfd	A. BUILDING: _____ B. WING _____	C 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 421	Continued From page 13 Continued record review revealed a Day Stay Agreement (Non-Residential Services Only) was signed by a Program representative and Tenant #2's spouse on 3/10/26. It indicated renewals were granted in 30-day increments. Renewal 1 was from 3/10/26 to 4/10/26. There was a daily fee for time up to eight hours. It indicated the agreement was not an occupancy agreement or residential services agreement. The participant was not admitted as a tenant, was not included in the census and it did not establish residency. Day stay participation did not include overnight accommodations, did not establish admission or tenancy, did not provide a right to occupy a bed or unit, was in day stay hours only, services were group based and were not clinical. Tenant #2 had not exceeded 60 days in the time period since he had started; however, he was scheduled two days per week; which would exceed the respite time allowed at the current agreement in a 12-month period (104 days in a 12-month period). 4. Record review on 5/13/26 of Tenant #3's documents revealed he had a Day Stay Assessment and Service Plan dated completed on 8/5/25. It indicated the start date of the day stay was 9/23/24. He attended Monday, Wednesday and Friday from 8:00 a.m. to 5:30 p.m. It indicated he required 24 supervision, occasional redirection, assist of one person with showers, every two hours checks and occasional behaviors cueing and redirection. Individualized Service Plans were dated 6/17/24 and 8/5/25. Tenant #3 was staged at a four on the GDS on 6/5/24, which indicated moderate cognitive decline. Continued record review revealed the Tenant Occupancy Agreement was signed by Tenant #3's spouse and Program representative on 6/10/24.	A 421		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	5710 GIBSON DRIVE NE CEDAR RAPIDS, IA 52411

(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 421	Continued From page 14 The agreement indicated for the move in date, day stay 6/10/24. The agreement indicated Day Stay Services and a daily fee. Tenant #3 attended three days per week (156 in a 12-month period); which exceeded the 60 days allowed in respite in 12-month period. 5. When interviewed on 5/14/26 at 10:20 a.m. the Wellness Director said Tenant #3 had been coming since 2024 and he attended three days per week. He did not have an apartment. He received one pill (which was new, and bathing). He would be over 60 days in a 12-month period. Tenant #2 was there one to two days per week. He did not receive any cares or medications but required 24-hour supervision. She said Tenant #2 was not over 60 days in a 12-month period. She said Tenant #2 and Tenant #3 were not respite or permanent but were day stay. Neither tenant had a negative impact on staffing or space. She said they could not have a day stay when they had a respite tenant and also could not have two day stay persons at the same (alternate schedule).	A 421		

PLAN OF CORRECTION (POC)

Community Name: CountryHouse Cedar Rapids Date : 6/18/2026

SECTION / TAG	VIOLATION	APPEAL?		PLAN OF CORRECTION	COMPLETED?
A421	481-69.39(1) Respite Care Services 481-69.39(231C) Respite care services. "Respite care services" means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person, or on request of the tenant as a trial of the program. An assisted living program that chooses to provide respite care services must meet the following requirements related to respite care services and be certified as an assisted living program. 69.39(1) Length of stay. Respite care services will be provided for no more than 30 consecutive days and for a total of no more than 60 days in a consecutive 12-month period beginning on the first day the individual stays in the program.	☐ YES ☐ NO	What Has Been Done to Correct?	Day stays have been ceased at CountryHouse Cedar Rapids effective 6/1/26.	☐ YES ☐ NO
			How Will Recurrence Be Prevented?	Day stays will no longer be offered at CountryHouse Cedar Rapids.	
			Person Responsible:	Director or Designee	
			Due Date:	6/1/26	
A122	481-67.3(2) Tenant Rights 481-67.3(231B,231C,231D) Tenant rights. All tenants have the following rights:	☐ YES ☐ NO	What Has Been Done to Correct?	Countryhouse Cedar Rapids will do monitoring of task documentation each week day to ensure that staff is documenting their tasks each shift. All care staff will be re-educated on the importance of documenting all tasks each shift. Countryhouse Cedar Rapids implemented the Care App on caregiver phones to assist with the compliance of documentation of care.	☐ YES ☐ NO

	67.3(2)?To receive care, treatment and services that are adequate and appropriate.		How Will Recurrence Be Prevented?	Executive Director, Health and Wellness Director or Designess will monitor task documentation follow up with staff that have missing documentation to correct the issue in a timely manner. Tasks will be monitored each week day for 6 weeks and weekly thereafter.	
			Person Responsible:	ED, HWD or Designee	
			Due Date:	6/22/2026	
A116	481-67.2(2) Program Policies and Procedures 67.2(2) The program shall follow the policies and procedures established by the program.	☐ YES ☐ NO	What Has Been Done to Correct?	All staff will be re-educated on notifying resident's responsible party immediately following any incident per Incident Reporting Policy.	☐ YES ☐ NO
			How Will Recurrence Be Prevented?	Executive Director and Health and Wellness Director or Designee will review incident reports each week day to ensure proper notifications have been made.	
			Person Responsible:	ED, HWD or Designee	
			Due Date:	6/22/2026	
SECTION / TAG	**VIOLATION**	**APPEAL?**		**PLAN OF CORRECTION**	**COMPLETE?**
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;	☐ YES ☐ NO	What Has Been Done to Correct?	Previous Health and Wellness Director is no longer employed with Countryhouse Cedar Rapids. The resident record cited during survey was reviewed and updated as appropriate. A review of residents receiving antibiotic therapy was completed to ensure physician orders and required documentation were present in the medical record.	☐ YES ☐ NO
			How Will Recurrence Be Prevented?	The HWD or designee will review residents receiving antibiotics or treatments each weekday to ensure orders, treatment documentation, and completion of therapy are documented appropriately. Staff will be re-educated on documentation requirements. Weekly audits will be conducted for 6 weeks and randomly thereafter.	
			Person Responsible:	ED, HWD or Designee	
			Due Date:	6/22/2026	

A 274	481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports need not be included in the tenant's medical record);	☐ YES ☐ NO	What Has Been Done to Correct?	All staff will be re-educated on when to complete incident reports per Incident Reporting policy.	☐ YES ☐ NO
			How Will Recurrence Be Prevented?	The ED, HWD, or designee will review documentation daily in ECP and shift reports each weekday and compare them to incident reports to ensure all reportable events have been documented. Missing incident reports will be completed promptly and staff will receive additional coaching as needed.	
			Person Responsible:	ED, HWD or Designee	
			Due Date:	6/22/2026	
A282	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.	☐ YES ☐ NO	What Has Been Done to Correct?	ECP was contacted to ensure service plans could be signed separately from the evaluation. ECP was able to provide a way to do this and community has been educated on how to send a service plan for signature.	☐ YES ☐ NO
			How Will Recurrence Be Prevented?	ED or Designee will review each service plan as appropriate form when they sign the document.	
			Person Responsible:	ED, HWD or Designee	
			Due Date:	6/22/2026	