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
	S0444	A. BUILDING: _____ B. WING _____	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STIRLINGSHIRE OF CORALVILLE AL	1140 KENNEDY PARKWAY CORALVILLE, IA 52241

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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: 61 Tenants with cognitive impairment: 4 Total census: 64 The following regulatory insufficiencies were cited related to the recertification visit conducted to determine compliance with certification of an Assisted Living Program:	A 000	see attached POC 5/28/26	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to follow established policy and procedures for documentation of tasks, which pertained to 3 of 6 tenants reviewed (Tenants #1, #3 #5) and documentation of food temperatures, which potentially affected all tenants (census of 64). Findings follow: 1. Record review on 3/24/26 of Tenant #1's file revealed the March Monthly Task Log reflected over 20 entries of dressing assistance on first and second shift charted as task not completed (TNC). Bathing was scheduled twice per week and the Monthly Task Log for March reflected one refusal, one out of facility and two TNC. There was no documented bathing assistance for	A 150		

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A 150	Continued From page 1 March. Record review on 3/25/26 of Tenant #3's file revealed the March Monthly Task Log reflected more than 20 entries of dressing assistance on first and second shift charted as task not completed (TNC). Bathing was scheduled twice per week and Monthly Task Log for March reflected completed bathing assistance twice and three entries of TNC. Record review on 3/25/26 of Tenant #5's file revealed the January Monthly Task Log reflected bathing was scheduled twice weekly. In January there were nine entries of TNC for bathing and there was no documented bathing assistance completed for January. The February Monthly Task Log reflected bathing was scheduled twice weekly. In February there were eight entries of TNC for bathing and there was no documented bathing assistance completed for February. Record review on 3/26/26 revealed the Program's Caregiver ADL Sign Off document dated 10/28/24 indicated some activities of daily living (ADLs) were information only and did not require staff to sign, they were "Show" tasks. Tasks that required staff to sign the tasks were completed were "Show and Chart." There were two sign off options to sign off the ADLS. It was noted to pay attention to the date and time of ADLs before signing off the task. The CNA/Caregiver OJT Training Checklist indicated staff were trained on the documentation policy and procedure. Continued record review revealed the ADL documentation was not completed as indicated above for Tenants #1, #3 and Tenant #5. When interviewed on 4/2/26 at 1:42 p.m. the	A 150		

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A 150	Continued From page 2 Director of Nursing (DON) indicated the expectation regarding the documentation of tasks was they were documented on the shift of the tasks. He confirmed the omissions on the task records above. When interviewed on 4/1/26 at 1:01 p.m. the Executive Director indicated staff should document tasks right away if possible or before they left their shift. She indicated regarding the expectations for task documentation, it was on the job checklist and the DON went over it with staff. 2. Observations on 3/24/26 at approximately 12:00 p.m. revealed Tenants were served soup at the start of the lunch. A comment was made by a tenant in the dining room that the soup was warm but was not hot. The special for the day served was chicken, wild rice and vegetables. There were also assorted beverages and ice cream served for dessert. Three tenants were interviewed on 3/24/26 and 3/25/26. A tenant indicated the food was not the best but improved recently. The vegetables were over-cooked, with a mushy texture and the food was not hot enough. Record review on 3/24/26 revealed the Program's Time/Temperature Food Preparation form from 3/15/26 to 3/24/26 indicated there were two items recorded for each day, the main entrée and the soup. The form indicated the name of the food, time, temperature and initials of the staff. The temperatures provided were above 135 degrees; however, none of the other food items served at meals (hot and cold foods) had recorded food temperatures. For the meal observed on 3/24/26 the chicken dish and soup had recorded	A 150		

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A 150	Continued From page 3 temperatures. The rice and vegetables served as the main entrée did not have a food temperature recorded. Continued record review on 3/24/26 revealed the Program's Safe Food Handling policy indicated food would be kept at appropriate temperatures for serving. Hot foods would be kept at 145 degrees Fahrenheit (F) or above and cold foods would be kept at 45 degrees F or below. The policy and procedure referenced a document (Food Temp Logs). When interviewed on 4/1/26 at 1:01 p.m. the Executive Director confirmed there was no other documentation of food temperatures and they were moving to an application that would include temperatures for all items. She indicated regarding food temperature complaints that some tenants liked their soup boiling and it was difficult to hold the temperature in eggs.	A 150		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by:	A 285		

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A 285	Continued From page 4 Based on interview and record review the Program failed to administer treatments as ordered by the physician. This pertained to 1 of 1 tenant reviewed that received staff assistance with blood glucose monitoring (Tenant #3). Finding follows: 1. Record review on 3/25/26 revealed Tenant #3's physician order dated 3/12/26, noted to reduce blood glucose monitoring to once daily in a.m. (fasting), to discontinue insulin and start metformin 500 milligram (mg), by mouth daily with every p.m. meal. The physician order was noted on 3/13/26 by the nurse. Continued review revealed Tenant #3's Medication/Treatment Error Report indicated on 3/13/26 an order was received for daily blood glucose check. The MAR was not updated to reflect the order it was listed as needed. The correct order was entered on 3/25/26. The PCP and power of attorney was notified. It was noted as a category 1 error, which was an error that reached the tenant; however, did not cause harm. Record review on 3/26/26 indicated a fax was sent to the PCP that indicated on 3/13/26 orders were received for fasting a.m. blood glucose checks daily. On 3/25/26 it was discovered the scheduled order was not entered into the electronic MAR. As needed blood glucose monitoring was listed but the last blood glucose reading was 3/13/26. It was requested to clarify the frequency of the blood glucose readings and parameters. Further record review revealed the March 2026 MARs reflected the discontinuation of the insulin and blood glucose monitoring four times daily and metformin; however, did not reflect the blood	A 285		

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A 285	Continued From page 5 glucose checks once daily in the a.m. It was ordered on 3/12/26 and was not completed as ordered at the time of order to the time of the review on 3/25/26. Additionally, the metformin 500 mg, ER tablet, take one tablet was scheduled at 10:00 a.m. and not with the p.m. meal as ordered. It was documented as given from 3/13/26 to 3/24/26; however, was not given at the ordered time. When interviewed on 4/1/26 at 2:30 p.m. the Assistant Director of Nursing indicated she asked for parameters for blood glucose monitoring for Tenant #3. Blood glucose monitoring was ordered once daily with parameters. It would have been completed from 3/13/26 to 3/25/26. There were no episodes of hyperglycemia or hypoglycemia. When interviewed on 4/2/26 at 1:42 p.m. the Director of Nursing reported there was no adverse side effect related to it.	A 285		
A 410	481-67.19(3)b Record Checks 67.19(3)b Conducting a background check. The program may access the single contact repository (SING) to perform the required background check. If the SING is used, the program shall submit the person's maiden name, if applicable, with the background check request. If SING is not used, the program must obtain a criminal history check from the department of public safety and a check of the child and dependent adult abuse registries from the department of human services. This REQUIREMENT is not met as evidenced	A 410		

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A 410	Continued From page 6 by: Based on interview and record review the Program failed to complete a background check that included a child abuse and dependent adult abuse registry background check. This pertained to 1 of 6 staff reviewed (Staff C). Finding follows: Record review on 3/23/26 revealed Staff C's training documents reflected a hire date of 12/9/25. The Single Contact License & Background Check (SING) was completed on 11/26/25. Further research was noted on the criminal history background check. The child abuse registry and dependent adult abuse registry indicated the database was not available, to try again later and error (two different forms for SING provided). A check of the child and dependent adult abuse registries were not completed prior to Staff C's employment or at the time of the review. When interviewed on 4/1/26 at 1:01 p.m. the Executive Director confirmed at the time of this interview the background check was completed again.	A 410		
A 415	481-67.19(3)c Record Checks 67.19(3)c If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program.	A 415		

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A 415	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to request an evaluation be completed to determine if a crime warranted prohibition of the person's employment. This pertained to 3 of 3 staff reviewed with a record indicated (Staff A, B and C). Findings follow: 1. Record review on 3/23/26 revealed Staff A's training documents reflected a hire date of 11/4/25. The Single Contact License & Background Check (SING) was completed on 10/22/25. No records were found for the abuse registries; however, the criminal history background check indicated further research needed due to a record found on 10/27/25. An evaluation was not completed and an evaluation determination was not received prior to Staff A's employment or at the time of the review on 3/23/26. 2. Record review on 3/23/26 revealed Staff B's training documents reflected a hire date of 11/5/25. The SING was completed on 10/27/25. No records were found for the abuse registries; however, the criminal history background check indicated further research needed due to a record found on 10/30/25. An evaluation was not completed and an evaluation determination was not received prior to Staff B's employment or at the time of the review on 3/23/26. 3. Record review on 3/23/26 revealed Staff C's training documents reflected a hire date of 12/9/25. The SING was completed on 11/26/25. The criminal history background check indicated further research needed due to a record found on 12/2/25. An evaluation was not completed and an evaluation determination was not received	A 415		

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A 415	Continued From page 8 prior to Staff C's employment or at the time of the review on 3/23/26. When interviewed on 4/1/26 at 1:01 p.m. the Executive Director confirmed there were no evaluations prior to the hire dates.	A 415		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to update service plans as needed and develop service plans that reflected the identified needs of the tenants. This pertained to 6 of 6 tenant files reviewed (Tenant #1, #2, #3, #4, #5 and #6). Findings follow: 1. Record review on 3/24/26 of Tenant #1's file revealed Tenant #1 had 15 falls documented on incident reports from 12/17/25 to 3/3/26, including falls that resulted in bruising and skin tears. Continued record review revealed a Program form indicated home health visited on 12/24/25 the purpose was an assessment/wound. A	A 350		

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A 350	Continued From page 9	A 350		

Program form indicated on 1/7/26 home health visited and the right leg wound dressing change was done. A verbal order was received to utilize tubigrips to bilateral lower extremities (BLE) to help with edema. The right lower extremity (RLE) had 4 + pitting edema and the left lower extremity) and the left lower extremity (LLE) had 2+ pitting edema. There was no change noted in the right pretibial wound.
An order was received on 2/18/26 to change leg bandage twice daily or anytime it was saturated.

Observation on 3/24/26 at approximately 12:15 p.m. during the medication pass revealed Tenant #1's lower extremity wound appeared to be a large, heavily scabbed area that was dark in color on her lower extremity.

Further record review revealed Tenant #1's service plan reflected orders for compression stockings on in the a.m. and remove at bedtime. The service plan also reflected orders for current wound care to the left shin. The service plan indicated a history of skin impairment; however, was not specific to the on-going wound on Tenant #1's shin. The service plan indicated Tenant #1 had a history of falls and provided standard interventions related to a clutter free apartment, appropriate foot wear and reminders to ask for assistance. The interventions provided were not individualized to Tenant #1's significant fall history.

When interviewed on 4/2/26 at 1:42 p.m. the Director of Nursing confirmed there were no additional fall interventions listed for Tenant #1 and he said her shin wound left open to air.

2. Observation on 3/24/26 at approximately 12:00 p.m. the lunch meal revealed Tenant #2

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A 350	Continued From page 10	A 350		

was assisted with eating by her spouse at the dining room table. She was seated in a high back wheelchair during the meal observation.

Record review on 3/24/26 of Tenant #2's service plan reflected Tenant #2 was independent with meal consumption and did not require assistance with meal consumption. Three meals per day were provided. The service plan did not address Tenant #2 required assistance with meals from her spouse or who assisted if the spouse was not able to assist or attend the meal.

Continued record review revealed Tenant #2's Progress Notes indicated the following:

-On 2/13/26 Tenant #2 was admitted to hospice services.

-On 3/17/26 a Broda chair was ordered to prevent Tenant #2 from sliding down.

-On 3/20/26 Tenant #2 had a new high back wheelchair.

Further record review revealed Tenant #2's service plan reflected she had a pummel cushion and seatbelt. The seatbelt was only used by family and not by staff. She used a walker and wheelchair. The service plan did not reflect the use of a high back wheelchair.

When interviewed on 4/2/26 at 1:42 p.m. the Director of Nursing confirmed Tenant #2's spouse often assisted her with eating at meals and it was not on the service plan. He indicated the service plan reflected a wheelchair for Tenant #2 but it was not specific to the high back wheelchair.

3. Record review on 3/25/26 of Tenant #3's file

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A 350	Continued From page 11 revealed Progress Notes indicated the following: -On 2/20/26 Tenant #3 was admitted to the hospital on 2/18/26 for frequent falls. A left knee x-ray showed a "perpendicular line of the patella could represent nondisplaced fracture." An immobilizer was placed on Tenant #3's left knee. Tenant #3 would require post-acute rehabilitation before returning to the Program. -On 3/5/26 Tenant #3 returned to the Program. -On 3/13/26 it noted on 3/12/26 new orders were received including to reduce blood glucose checks to once daily, discontinue insulin and start metformin. It also indicated to use the knee brace until 4/1/26 then as needed after that time. Continued record review revealed Tenant #3's service plan dated 3/13/26 reflected the order for the left knee brace, to keep in place at all times including with sleep. Could remove for dressing toileting as needed. The service plan did not reflect the nondisplaced fracture of the patella. When interviewed on 4/2/26 at 1:42 p.m. the Director of Nursing confirmed the fracture was not on the service plan for Tenant #3. 4. Record review on 3/25/26 of Tenant #4's file revealed the February Monthly Task Logs reflected five refusals of bathing and one entry marked as other. The March Monthly Task Logs reflected four refusals of bathing. Continued record review revealed Tenant #4's service plan reflected staff assisted Tenant #4 with bathing twice per week. The service plan did not reflect Tenant #4's bathing refusals as noted on the Monthly Task Logs and interventions	A 350		

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A 350	Continued From page 12 related to bathing refusals. Further record review revealed Progress Notes indicated the following: -On 3/2/26 it noted on 2/28/26 at 1:30 p.m. staff responded to Tenant #4's apartment and she was on the floor. She reported she did not hit her head but staff noted swelling and bruising to the back of her. Staff attempted to help Tenant #4 eat but she aspirated. Staff was directed to send Tenant #4 out to the emergency department. It was noted she had two falls. -On 3/3/26 Tenant #4 had a fever of 101 degrees upon arrival at the hospital. A urinalysis (UA) showed infection. The head computed tomography (CT) did not show any intracranial findings. She was admitted for a urinary tract infection (UTI) and delirium. -On 3/5/26 it was noted the UTI was cleared up and Tenant #4 would be discharged to return to the Program. Tenant #4 transferred with assistance of one person and had a walking boot on the right foot. -On 3/24/26 it was noted staff reported Tenant #4 had excessive soiling and refused care. Continued record review revealed the service plan dated 3/5/26 indicated Tenant #4 was independent with toileting needs. For transfers the service plan indicated Tenant #4 required "stand by/assistance of one person with ambulation and transfers." The service plan did not reflect the walking boot or injury that required the walking boot. When interviewed on 4/2/26 at 1:42 p.m. the	A 350		

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A 350	Continued From page 13 Director of Nursing confirmed the fracture was not on the service plan or the boot for Tenant #4. 5. Record review on 3/25/26 of Tenant #5's file revealed Progress Notes indicated the following: -On 1/12/26 staff communication was received from 1/9/26 regarding Tenant #5 requiring the assistance of two staff and increased toileting assistance on third shift. Staff today reported one assist. -On 2/12/26 staff communication was received from 2/11/26 regarding Tenant #2 having a hard time standing and transferring. -On 2/25/26 staff communication was received from 2/25/26 regarding Tenant #5 have urinary urgency but she was not able to void. There was a strong odor noted in the urine. She had used her pendant frequently and had new agitation. -On 2/26/26 it was noted a new order was received for a UA. -On 2/27/26 staff communication was received from 2/26/26 and there was new continence of bowel and bladder for Tenant #5. It was noted Tenant #5 was not aware of the incontinence. A change of condition was to be completed for incontinence. -On 3/24/26 communication was received for 3/24/26. Tenant #5 used her pendant often but was not voiding when taken to the bathroom. Continued record review revealed Tenant #5's service plan Tenant #5 required moderate assistance of one person with toileting. It reflected that she wore protective undergarments. It did not reflect the issue noted above related to	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0444	A. BUILDING: _____ B. WING _____	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STIRLINGSHIRE OF CORALVILLE AL	1140 KENNEDY PARKWAY 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 350	Continued From page 14	A 350		

not voiding when taken to the bathroom. The service plan also reflected that for transfers she required moderate assistance of staff or spouse. She was able to transfer with stand by assistance. She had no behavior issues. The service plan did not reflect her difficulty with standing at times or agitation.

When interviewed on 4/2/26 at 1:42 p.m. the Director of Nursing confirmed going to the bathroom was hit and miss for Tenant #5 and she was slow to stand up.

6. Record review on 3/26/26 of Tenant #6's file revealed Progress Notes indicated the following:

-On 2/26/26 Tenant #6 went to the ED after a fall. Pendant responses were reviewed and she pushed her pendant frequently about 4:00 p.m. through the night. It was noted she used the pendant up to 60 times.

-On 3/2/26 staff communication was received from 2/28/26. Tenant #6 was not stable when getting and nearly fell when leaving the apartment.

-On 3/12/26 staff communication received on 3/11/26 indicated Tenant #6 had increased soiling, frequent urination and agitation.

When interviewed on 3/24/26 at 10:01 Staff D reported some days Tenant #6 took two people to assist her. Some days Tenant #6 could be assisted with toileting and dressing with one person, the other day it took people. Staff D indicated Tenant #6 pushed her pendant often.

Continued record review revealed Tenant #6's service plan dated 1/12/26 indicated Tenant #6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0444	A. BUILDING: _____ B. WING _____	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STIRLINGSHIRE OF CORALVILLE AL	1140 KENNEDY PARKWAY 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 350	Continued From page 15 required the assistance of one person with toileting and one person assist with dressing. The service plan reflected Tenant #6 did not have any behavior issues. The service plan indicated Tenant #6 was independent with the pendant and used it appropriately. The service plan did not reflect issues as noted above with increased incontinence, frequent use of the pendant, agitation and at times required the assistance of two staff with care. When interviewed on 4/2/26 at 1:42 p.m. the Director of Nursing confirmed there was a a change from a necklace pendant to a wrist pendant for Tenant #6 (regarding pendant use) and she required the assistance of one person. The Director of Nursing confirmed all service plans requested were provided for the tenants reviewed.	A 350		

STIRLINGSHIRE
DIAL SENIOR LIVING

Plan of Correction for Stirlingshire of Coralville

In response to

Stirlingshire of Coralville (ALP) Recertification Visit

Dates: 3/17/2026- 4/2/2026

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Regulatory Insufficiency: 481-67.2(3) Program Policies and Procedures
67.2(3) The program shall follow the policies and procedures established by the program

1. **Elements detailing how the program will correct the insufficiency.**
   a. All nursing team members will be re-educated on ADL documentation.
   b. All dining team members will be re-educated on the food temping process.
2. **What measures will be taken to ensure the problem does not recur.**
   a. The DON/ADON or designee will perform random audits of documentation to ensure compliance.
3. **How the program plans to monitor performance to ensure compliance.**
   a. The Regional Nurse and/or designee will periodically audit supporting documentation for completion during visits to community.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. This regulatory insufficiency will be corrected by 5/28/2026.

Regulatory Insufficiency: 481-67.5(2)f(4) Medications
67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant

1. **Elements detailing how the program will correct the insufficiency.**
   a. Tenant #3's EMAR was updated on 3/25/2026 to reflect the correct blood sugar order.
2. **What measures will be taken to ensure the problem does not recur.**
   a. The DON, ADON, and/or designee will routinely review resident medication administration records to ensure compliance.
3. **How the program plans to monitor performance to ensure compliance.**
   a. The Regional Nurse and/or designee will periodically audit supporting documentation for completion during visits to community.

STIRLINGSHIRE
DIAL SENIOR LIVING

4. **The date by which the regulatory insufficiency will be corrected.**
    a. This regulatory insufficiency will be corrected by 3/25/2026.

Regulatory Insufficiency: 481-67.19(3)b Record Checks
67.19(3)b Conducting a background check. The program may access the single contact repository (SING) to perform the required background check. If the SING is used, the program shall submit the person's maiden name, if applicable, with the background check request. If SING is not used, the program must obtain a criminal history check from the department of public safety and a check of the child and dependent adult abuse registries from the department of human services.

1. **Elements detailing how the program will correct the insufficiency.**
    a. Team member C's background was completed again and employment was terminated on 3/27/26
2. **What measures will be taken to ensure the problem does not recur.**
    a. The Executive Director, Office Manager, or designee will thoroughly review all background checks when they are completed to ensure that no further action is needed.
3. **How the program plans to monitor performance to ensure compliance.**
    a. Executive Director or designee will perform random file audits to ensure compliance.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. This regulatory insufficiency was corrected by 3/30/2026

Regulatory Insufficiency: 481-67.19(3)c Record Checks
67.19(3)c If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program.

1. **Elements detailing how the program will correct the insufficiency.**
    a. Team member's A, B, and C had their background check and evaluations completed again as applicable
    b. Team member C's employment was terminated on 3/27/26
2. **What measures will be taken to ensure the problem does not recur.**
    a. The Executive Director, Office Manager, or designee will thoroughly review all background checks when they are completed to ensure that no further action is needed.
3. **How the program plans to monitor performance to ensure compliance.**
    a. Executive Director or designee will perform random file audits to ensure compliance.

STIRLINGSHIRE
DIAL SENIOR LIVING

4. **The date by which the regulatory insufficiency will be corrected.**
    a. This regulatory insufficiency was corrected by 3/30/26

Regulatory Insufficiency: 481-69.26(1) Service Plans
69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.

1. **Elements detailing how the program will correct the insufficiency.**
    a. Tenant's #1, #2, #3, #4, #5 and #6 service plans to be updated adequately to reflect specific care needs.
2. **What measures will be taken to ensure the problem does not recur.**
    a. Assessments and Service Plans will be created and kept updated to adequately reflect each tenant's individualized care needs.
3. **How the program plans to monitor performance to ensure compliance.**
    a. The Regional Nurse and/or designee will complete random audits of resident chart notes, assessments, and service plans to ensure accuracy and compliance.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. This regulatory insufficiency will be corrected by 5/28/2026.

Sincerely,

Amy Kubik-Hasley
Executive Director