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
	S0445	A. BUILDING: _____ B. WING _____	C 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STIRLINGSHIRE OF CORALVILLE MC	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 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: 0 Tenants with cognitive impairment: 18 Total census: 18 The following regulatory insufficiencies were cited related to the investigation of Complaint #130582-C, Incidents #130776-I, #130914-I and #131096-I and the recertification visit conducted to determine compliance with certification a Dedicated Dementia Specific 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 interview and record review the Program failed to follow established policies and procedures related to door alarms, which pertained to 1 of 2 tenants reviewed that eloped (Tenant #2), incident reports, which pertained to 2 of 2 tenants involved in an incident of a sexual nature (Tenant #4 and Tenant C1) and documentation of tasks, which pertained to 2 of 5 current tenants reviewed (Tenant #3 and Tenant #5). Findings follow: 1. Record review on 3/26/26 revealed Tenant #2's incident report dated 11/27/25, indicated at	A 150		

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A 150	Continued From page 1 1:15 p.m. Tenant #2 was observed in the general population lobby. Video footage confirmed he exited the side memory care door at 1:18 p.m. When Tenant #2 pressed on the side exit door, a tenant and family member also arrived at the front memory care entrance. Staff H assisted them out of the front entrance and believed the alarm was related to that door. Staff I and Staff J were in another tenant's apartment. Staff J left the apartment at 1:19 p.m. Staff J went to disarm the front door at 1:20 p.m. and determined the front door was not alarming. Staff went to the side door and confirmed the alarm. A search was started. Staff H went to the front entrance to memory care. Staff J searched room to room and Staff I searched the stairwell and area then returned to search. Staff H located Tenant #2 at the front desk inside of the general population building. Tenant #2 was escorted back to the unit at 1:24 p.m. Continued record review of an Incident Investigation Report dated 11/28/25 indicated on 11/27/25 Tenant #2 eloped. The investigative conclusion indicated there was a lack of urgency to identify the door alarm and identify the reason for the door alarm. Staff were re-educated on elopement and door alarm policies and procedures. The summary indicated Tenant #2 exited the side door at 1:18 p.m. When he pressed on the door, a family member and tenant arrived at the memory care entrance. Staff H assisted them out of the front door and believed the alarm sounding was related to that door. Staff I and Staff J assisted another tenant in an apartment. At 1:20 p.m. Staff J went to the front door to disarm the door and determined it was not alarming. Staff checked the side door and confirmed it was the alarming door. At 1:23 p.m. Staff H located Tenant #2 at the front desk in the	A 150		

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general population building. He was escorted back to the memory care unit. On 11/28/25, Tenant #2 was assessed by the Director of Nursing (DON) and had no injuries.

Staff statements collected by the Program revealed the following:

-Staff H indicated when a family member and tenant went out of the door the alarm started going off, she went and let them out. Staff I and Staff J came out from a tenant's apartment with the key to turn off the alarm and they realized it was the side door. Staff knew it was Tenant #2. He walked past her when she was opening the door for family. When Staff I realized it was Tenant #2, she ran downstairs and she ran to the front desk. Tenant #2 was found at the front desk and indicated he was looking for his car. Staff H indicated Tenant #2 was the only one to try that door.

-Staff I indicated she and Staff J were toileting another tenant and faintly heard a ring. As staff finished up, they ran out of the apartment. They saw Staff H and she indicated it was possibly family as they were standing near the front door. Staff H did not have a key and she was coming to get it from staff. Before Staff H could get the key, the staff realized it was the side door. Staff I went downstairs but did not see anyone. The door leads to the outside. Staff H went to the front to check and found Tenant #2. While Staff H did that Staff I started a head count.

-Staff J indicated she was with Staff I assisting a tenant in the apartment. They heard the door alarm, came out and checked the front door then realized it was the rear exit door. Staff I went out the door and downstairs to search for Tenant #2.

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A 150	Continued From page 3 Staff knew he (Tenant #2) would be the only one that would try to go that way. Staff H went to the front exit and found Tenant #2 in the lobby. Further record review on 3/26/26 revealedTenant #2's file indicated Tenant #2 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. The service plan dated 11/19/25 reflected Tenant #2 had a history of wandering, entering other tenant's apartments and exit seeking. The service plan was updated to reflect Tenant #2 exited the building on 11/27/25 and 12/18/25. When interviewed on 3/31/26 at approximately 2:30 p.m. Staff H reported she worked with Staff I and Staff J. It was busy with families coming in and out for Thanksgiving. A tenant's family member wanted her to let him out. She heard the door alarm going off and the family member was at the door indicated there was no one at reception desk and Staff H told the family member how to sign out a tenant. Staff H thought it was the front door. Staff H indicated Tenant #2 walked past her. Staff I and Staff J had the key and the phone. Staff I reported she thought it was the other door. Staff H did not have a key or phone. Staff I thought it was the stairwell door and knew it was Tenant #2. A head count was completed. Staff I went downstairs and came back up. Staff H went to the front entrance and Tenant #2 was in the lobby. Tenant #2 indicated it was too cold and came back inside. Staff H reported it was three to four minutes from when the alarm to when Tenant #2 was seen. He had no injuries and indicated he was looking for his car. It was cold, and Staff H thought Tenant #2 had a jacket. Staff J notified the nurse. Staff H thought it was the front door alarm.	A 150		

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A 150	Continued From page 4 When interviewed on 3/31/26 at approximately 10:15 a.m. Staff I reported she was in another tenant's apartment with Staff J. She heard the door go off and there was a lag and she received an alarm on the phone. Staff I indicated there was a lag, she heard the beeping then received the notification on the phone. She ran out and saw her co-worker at the front door. Staff I went to the side door, the phone indicated it was the side door. She received both alerts for the doors. Staff I went downstairs and did not see anyone. Staff I believed it was Tenant #2. A head count was completed even though she believed it was Tenant #2. Someone from assisted living came in and had him. Tenant #2 went downstairs and most likely outside. He was dressed appropriately for the weather and had no injuries. When interviewed on 4/1/26 at 4:44 p.m. Staff J reported she worked on first shift with Staff H and Staff I. Staff J was in another tenant's apartment changing a tenant with Staff I. Staff vaguely heard an alarm. Staff I had a phone. At first staff thought it was a tenant's family member (door alarm). It went a bit longer than usual. She reported if both alarms were going off it could not be distinguished (which alarm door). Staff J went to shut off the door alarm and it was determined it was the back door. Staff I said it was Tenant #2 and she took off downstairs. Staff J checked apartments and Staff H went to the front lobby. Tenant #2 left the building and came back around the building. Tenant #2 indicated he was going for a walk. He had no injuries. When interviewed on 4/1/26 at 2:30 p.m. the Assistant Director of Nursing (ADON) reported she was on-call and staff notified her. The ADON notified the Executive Director and the Director of Nursing (DON). She indicated staff reported two	A 150		

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staff were in a tenant's apartment helping a tenant. Staff H was the front door, letting visitors out and believed it was that alarm. Staff checked the door and realized it was the other door. Tenant #2 was found at the front desk. He had no injuries and was wearing jeans, a long sleeved shirt, jacket and shoes. She indicated it was suggested when the alarms went off to look at the red-light indicators.

When interviewed on 4/1/26 at 3:51 p.m. the DON indicated staff checked the wrong door and thought it was the front door alarm and someone was being let out. Tenant #2 walked around the side the building and was found at the front desk. Tenant #2 did not sustain any injuries. The door alarm functioned; staff thought it was the wrong door. Tenant #2 indicated he was looking for his car. He reported it was one and half minutes before it was realized it was the side door.

On 4/1/26 weather conditions were provided by the State Climatologist for 11/27/25 at 1:15 p.m. in Coralville and were as follows: temperature was 32 degrees, relative humidity was 49%, winds were out of the west northwest at 18 miles per hour (mph), with gusts to 31 mph, the wind chill was 21 degree and there were clear skies.

Observation on 3/31/26 at 11:47 a.m. revealed the possible terrain Tenant #2 traveled. From the side exit door there were stairs that went upstairs to the second floor (general population) and stairs that went downstairs to a lower-level exit door. That exit door went to the exterior of the building. There was a sidewalk that went around the building, crossed in front of the driveway to garage entrance, it continued around the front of the building and was next to the parking lot. The sidewalk continued to the front entrance of the

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general population section of the building. There was an exterior door, a vestibule and another door that entered into the front lobby. It took approximately 2.22 minutes to walk from the lower-level exit door to the main entrance. Tenant #2 would have also traveled down stairs to get to the lower-level exit door.

Record review on 3/23/26 of the Program's Alarmed Door for Locked Memory Care Unit policy and procedure indicated all doors that went to the outside were alarmed/coded doors. If a door alarm alarmed staff were to complete a physical check of the area outside of the door that alarmed to ensure a tenant was not outside of the building. Staff completed a physical check of each tenant. If assistance was required completing a physical check, staff would call for additional staff to request assistance.

2. Record review on 3/30/26 revealed Tenant #4's incident report dated 10/10/25, indicated at 7:15 p.m. Tenant #4 was found in another tenant's apartment on the bed. The incident report indicated Tenant #4 was removed from the apartment. The DON and power of attorney (POA) were notified.

Continued record review on 3/30/26 of an incident report indicated on 10/10/25 at 7:15 p.m. Tenant C1 was found in his apartment with a female tenant. The DON was notified.

Further record review revealed staff statements collected by the Program for the 10/10/25 incident indicated the following:

a. Staff B's statement indicated she completed rounds and saw them on the bed. The male tenant told Staff B "she's my wife." Staff B thought

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they were going to sleep. "I just said good night to them."

b. Staff C's statement indicated the last time she saw Tenant #4 was at 6:00 (p.m.) in the television room. When Staff C went to her apartment about 7:00 p.m. she was not in her apartment. Staff C let the staff know, staff started looking for her and Staff D found Tenant #4 in with Tenant C1.

c. Staff D's statement indicated at about 7:00 p.m. Staff D was informed by one of the staff that one of the tenants was missing. Staff D directed the staff to complete a search at the front while Staff D started rounds. Staff D found Tenant #4 on the bed in a male tenant's apartment.

Continued record review of Tenant #4's file revealed Tenant #4 ' s Progress Notes indicated the following:

a. On 10/13/25 a fax was sent to the primary care provider (PCP) related to the incident on 10/10/25. The on-call nurse was notified on 10/10/25 that staff could not find Tenant #4 at about 7:15 p.m. and started a search. Tenant #4 was located in another tenant's apartment. Staff observed the other tenant, nude and on top of Tenant #4 in the bed. Tenant #4 was fully clothed and no "penetration occurred." No harmful acts were completed to Tenant #4. When assessed on 10/13/25, Tenant #4 was doing well and had no concerns. Staff would be reeducated on elopement procedures and hourly rounds.

b. On 10/15/25 the male tenant was completely nude and Tenant #4 was fully clothed. Staff reported Tenant #4 had pants on and no signs of disheveled clothing. There were no indicators or reports of "penetration from female resident." The

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families of both tenants were notified and fax was sent to Tenant #4's PCP.

Further record review of Tenant C1's file revealed Progress Notes indicated on 10/13/25 it was noted on 10/10/25 the on-call nurse was notified Tenant C1 was in his apartment with another tenant. Staff found Tenant C1 nude and on top of the other tenant when in bed. Tenant C1 did not perform any acts of harm to the other tenant. The other tenant was completely clothed and was removed from the apartment.

When interviewed on 3/31/26 at 10:52 a.m. Staff B reported for rounds she went to Tenant #4's apartment and Tenant #4 was not in her bedroom or bathroom. Staff B told Staff D and staff kept looking for her. Staff D found Tenant #4 and Tenant C1 was on top of her. Tenant #4 had tears in her eyes. Staff B indicated Tenant #4 did not have pants on and Tenant C1 did not have pants on. It was reported from Staff D. Tenant #4 was taken out of the apartment and dressed by Staff D. The on-call nurse was called by Staff D. Staff B reported she thought Tenant #4 followed Tenant C1 to the apartment. Tenant #4 was crying and was scared. Tenant C1 indicated he wanted Tenant #4 to come to bed with him. Staff B reported it had not happened before. Tenant #4 was ambulatory and Tenant C1 walked with a walker. Staff would have seen Tenant C1 before on rounds, but she could not remember what time.

When interviewed on 4/1/26 at 10:10 a.m. Staff C reported she was a new staff member. She was doing rounds and observed Tenant C1 and Tenant #4 in bed. Tenant C1 told her Tenant #4 was his wife. When she observed them, Staff C saw her try to pull her pants up and he had a

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blanket, so she was not able to see the state of his dress. After Tenant C1's door there were two more rounds then after that Staff C told staff and staff indicated that was not his wife. The staff removed Tenant #4 from the apartment and notified the DON. Staff C was new and thought it was Tenant C1's wife.

When interviewed on 3/31/26 at approximately 1:05 p.m. Staff D indicated she worked as the medication passer in memory care. Staff D was getting medications ready and Staff B was doing rounds. Staff B reported one person was missing; she asked and it was Tenant #4. Staff D started a head count, asked one of the staff to go to the front desk to check. Staff D went to Tenant C1's apartment then found Tenant #4 and Tenant C1 in Tenant C1's bed. Staff D reported Tenant C1 was completely dressed and Tenant #4's pants were down. Staff D reported Tenant #4 was very uncomfortable. Tenant #4 barely spoke (baseline) but she was shaking, stressed and was not herself. Tenant #4 indicated she needed to go home, which she meant as her apartment. Staff D took Tenant #4 to her apartment, got her dressed and reassured her that she was safe. The families of Tenant #4 and Tenant C1 were both notified and the nurse was notified. There were no injuries to the tenants. Tenant C1 was kind of aggressive when he was redirected and Staff B assisted. Staff D saw Tenant #4 and Tenant C1 at dinner at 6:00 p.m. Staff D indicated Tenant C1 had a big bed, his bathroom was first and they were on the other side of the bed as to why Staff B did not find Tenant #4. Staff D reported Tenant C1 was doing "weird actions" towards Tenant #4 and there was no response from Tenant #4. When Staff D came in she saw Tenant C1 on top of Tenant #4 and he was trying to take off her top. Staff D immediately intervened. There had been

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nothing similar between them. Tenant C1 had at times behaviors towards staff. Staff thought there was an incident report but she knew staff wrote statements. Staff D indicated there were no issues the rest of the shift.

Continued record review on 4/2/26 revealed the Program's Incident Report policy and procedure indicated the report would include the name of the tenant involved, date and time the incident occurred, location of the incident, a description of the incident and the names of the all the staff and others present during the incident.

Further record review revealed the incident reports completed related to the 10/10/25 incident between Tenant #4 and Tenant C1 did not include all required information per policy including a description of what occurred.

When interviewed on 4/2/26 at 1:42 p.m. the DON indicated the staff put the incident report in the electronic records system. The Progress Notes had detail regarding the incident. He confirmed all incident reports requested were provided.

3. Record review on 3/30/26 of Tenant #3's file revealed the January Monthly Task Log reflected bathing was scheduled twice weekly. It was charted as a task not completed (TNC) twice in January.

Record review on 3/30/26 of Tenant #5's file revealed over 40 entries of dressing assistance on first and second shift charted as TNC. Bathing was scheduled twice per week and the Monthly Task Log for February reflected one completed bath and seven charted as TNC. The March Monthly Task Log reflected bathing was

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A 150	Continued From page 11 scheduled twice per week and the task log reflected no completed bathing for March and nine charted as TNC. Record review on 3/26/26 of Caregiver ADL Sign Off document indicated some activities of daily living (ADLs) were information only and did not require staff to sign, they were "Show" tasks. Tasks that required signing off that 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 ADLs documentation was not completed as indicated above for Tenant #3 and Tenant #5. When interviewed on 4/2/26 at 1:42 p.m. the Director of Nursing (DON) indicated the expectation regarding the documentation of tasks was that they were documented on the shift of the tasks. He confirmed the omissions on the task records above.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate.	A 160		

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A 160	Continued From page 12 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 current tenant reviewed (Tenant #4) and 1 of 1 discharged tenant reviewed involved in an incident of a sexual nature (Tenant C1). Findings follow: 1. Record review on 3/30/26 of an incident report indicated on 10/10/25 at 7:15 p.m. Tenant #4 was found in another tenant's apartment on the bed. The incident report indicated Tenant #4 was removed from the apartment. The Director of Nursing (DON) and power of attorney (POA) were notified. Continued record review revealed Tenant #4 was staged at Global Deterioration Scale (GDS) of five, which indicated moderately severe cognitive decline and her diagnoses included Alzheimer's disease with early onset and dementia in other diseases, moderate with psychotic disturbance. Her service plan dated 7/2/25 reflected she had occasional behavior and was allowed to hold hands with another tenant (not Tenant C1). Progress Notes indicated the following: -On 10/13/25 a fax was sent to the primary care provider (PCP) related to the incident on 10/10/25. The on-call nurse was notified on 10/10/25 that staff could not find Tenant #4 at about 7:15 p.m. and started a search. Tenant #4 was located in another tenant's apartment. Staff observed the other tenant, nude and on top of Tenant #4 in the bed. Tenant #4 was fully clothed and no "penetration occurred." No harmful acts	A 160		

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were completed to Tenant #4. When assessed on 10/13/25, Tenant #4 was doing well and had no concerns. Staff would be reeducated on elopement procedures and hourly rounds.

-On 10/15/25 the male tenant was fully nude and Tenant #4 was fully clothed. Staff reported Tenant #4 had pants on and no signs of disheveled clothing. There were no indicators or report of "penetration from female resident." The families of both tenants were notified and fax was sent to Tenant #4's PCP.

2. Record review on 3/30/26 of an incident report indicated on 10/10/25 at 7:15 p.m. Tenant C1 was found in his apartment with a female tenant. The DON was notified.

Further review of Tenant C1's file revealed Tenant C1 was staged at a four on the GDS, which indicated moderate cognitive decline. Tenant C1's service plan reflected he had occasional behavior. He was known to kiss, grope, show affection and attempted sexual advances with female tenants. Staff was to remove him from the situation when observed and notify the nurse. The service plan also indicated Tenant C1 would receive hourly safety checks.

Tenant C1's Progress Notes indicated the following:

-On 8/15/25 staff reported on 8/14/25 (first shift) Tenant C1 attempted to kiss a tenant in the dining room and attempted to take her back to his apartment. He was "Making her believe that he is her husband." Staff said they separated the two tenants but he "continues to seek her out."

-On 8/15/25 staff reported on 8/14/25 (second

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shift) Tenant C1 attempted to take female tenants to his apartment, held hands, sat with them and it was noted he was unable to be redirected.

-On 8/21/25 it was noted on 8/19/25 Tenant C1 was seen bringing a female tenant to his apartment. Staff went in and observed Tenant C1 with his penis out of his pants. The other tenant was fully dressed. Family preferred to use medications to reduce the behaviors.

-On 10/13/25 it was noted on 10/10/25 the on-call nurse was notified Tenant C1 was in his apartment with another tenant. Staff found Tenant C1 nude and on top of the other tenant when in bed. Tenant C1 did not perform any acts to harm the other tenant. The other tenant was fully clothed and was removed from the apartment.

-On 10/13/25 it was noted staff reported on 10/12/25 that he had increased incontinence, pinched a staff's breasts and tried to grab between staff's legs.

3. Record review of the Safety Checks document for 10/10/25 indicated hourly rounds were signed off as completed at 6:00 p.m. with 19 tenants accounted for and again at 7:00 p.m. 19 tenants recorded and there were no staff initials recorded next to the number.

Further record review revealed staff statements were collected by the Program for the 10/10/25 and indicated the following:

a. Staff B's statement indicated the last time she saw Tenant #4 was at 6:00 (p.m.) in the television room. When Staff B went to her apartment about 7:00 p.m. she was not in her apartment. Staff B let the staff know, staff started looking for her and

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A 160	Continued From page 15 Staff D found Tenant #4 in with Tenant C1. b. Staff C's statement indicated she completed rounds and saw them on the bed. The male tenant told Staff C "she's my wife." Staff C thought they were going to sleep. "I just said good night to them." c. Staff D's statement indicated at about 7:00 p.m. Staff D was informed by one of the staff that one of the tenants was missing. Staff D directed the staff to complete a search at the front while Staff D started rounds. Staff D found Tenant #4 on the bed in a male tenant's apartment. When interviewed on 3/31/26 at 10:52 a.m. Staff B reported for rounds she went to Tenant #4's apartment and Tenant #4 was not in her bedroom or bathroom. Staff B told Staff D and staff kept looking for her. Staff D found Tenant #4 and Tenant C1 was on top of her. Tenant #4 had tears in her eyes. Staff B indicated Tenant #4 did not have pants on and Tenant C1 did not have pants on. It was reported from Staff D. Tenant #4 was taken out of the apartment and dressed by Staff D. The on-call nurse was called by Staff D. Staff B reported she thought Tenant #4 followed Tenant C1 to the apartment. Tenant #4 was crying and was scared. Tenant C1 wanted Tenant #4 to come to bed with him. Staff B indicated it had not happened before. Tenant #4 was ambulatory and Tenant C1 walked with a walker. Staff would have seen Tenant C1 before on rounds, but she could not remember what time. When interviewed on 4/1/26 at 10:10 a.m. Staff C reported she was a new staff member and was doing rounds and observed Tenant C1 and Tenant #4 in bed. Tenant C1 told her that Tenant #4 was his wife. When she observed them, Staff	A 160		

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C saw her try to pull her pants up and he had a blanket, so she was not able to see the state of his dress. After Tenant C1's door there were two more rounds then after that Staff C told staff and staff indicated that was not his wife. The staff removed Tenant #4 from the apartment and notified the DON. She indicated she was new and thought it was Tenant C1's wife.

When interviewed on 3/31/26 at approximately 1:05 p.m. Staff D reported she worked as the medication passer in memory care. Staff D was getting medications ready and Staff B was doing rounds. Staff B reported one person was missing then she asked and it was Tenant #4. Staff D started a head count, asked one of the staff to go to the front desk to check. Staff D went to Tenant C1's apartment and found Tenant #4 and Tenant C1 in Tenant C1' bed. Staff D reported Tenant C1 was fully dressed and Tenant #4's pants were down. Staff D indicated Tenant #4 was very uncomfortable. Tenant #4 barely spoke (baseline) but she was shaking, stressed and was not herself. Tenant #4 indicated she needed to go home, which meant her apartment. Staff D took Tenant #4 to her apartment, got her dressed and reassured her that she was safe. The families of Tenant #4 and Tenant C1 were both notified and the nurse was notified. There were no injuries to the tenants. Staff D reported Tenant C1 was kind of aggressive when he was redirected and Staff B assisted. Staff D saw Tenant #4 and Tenant C1 at dinner at 6:00 p.m. Tenant C1 had a big bed, his bathroom was first and they were on the other side of the bed as to why Staff B did not find Tenant #4. Staff D indicated Tenant C1 was doing "weird actions" towards Tenant #4 and there was no response from Tenant #4. When Staff D came in she saw Tenant C1 on top of Tenant #4 and he was trying to take off her top. Staff D immediately

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A 160	Continued From page 17 intervened. There had been nothing similar between them. Tenant C1 had at times behaviors towards staff. Staff thought there was an incident report but she knew staff wrote statements. Staff D said there were no issues the rest of the shift. When interviewed on 4/1/26 at 2:30 p.m. the Assistant Director of Nursing (ADON) reported the DON was on-call for that situation. The ADON was told Tenant C1 was in his apartment, Tenant #4 came into this apartment. Tenant C1 was not clothed and Tenant #4 was clothed. There were no injuries and neither tenant was able to say what occurred. Staff saw Tenant #4 in the television room at 6:00 p.m. The ADON said it sounded like as soon as Tenant #4 was found, she was removed. When interviewed on 4/1/26 at 3:51 p.m. the DON reported staff called and notified him of the incident. Staff reported they were searching for Tenant #4 and found her in Tenant C1's apartment. Tenant #4 was fully clothed and Tenant C1's penis was exposed. They were located near the bed. Neither tenant was able to recall what occurred. He questioned staff regarding how long the tenants had been together and they had been seen in the main room watching television. There were no visible injuries. He indicated he did not recall Staff C's statement at all. He had no concerns for their safety and there was no prior incident between them.	A 160		
A 325	481-67.9(1) 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.	A 325		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review the Program failed to have a sufficient number of trained staff available at all times to fully meet a tenant's identified needs. This pertained to 1 of 2 tenants reviewed that eloped (Tenant #2). Finding follows:

1. Record review on 3/26/26 of an incident report dated 12/18/25, indicated at approximately 3:46 p.m. Tenant #2 was observed on the second floor of the general population. Video footage confirmed he exited through the side exit door at 3:43 p.m. He was observed walking on the second floor by the Executive Director and returned to the memory care unit at 3:49 p.m.

Continued record review revealed the Incident Investigation Report indicated the investigation conclusion was Staff B and Staff C left the unit. Disciplinary action was provided for the two staff that left the memory care unit together. Education was provided to nursing staff regarding communication when leaving the unit. At 3:00 p.m. Staff B completed rounds and all tenants were accounted for. After the rounds, Staff B and Staff C left the unit to assist with an activity in the general population. Video footage revealed Tenant #2 approached the door at 3:42 p.m. and exited the memory care unit at 3:43 p.m. Staff L heard a door alarm, responded to the door alarm at the front entrance, realized it was not the source of the alarm and went to the stairwell door. Staff L believed it was Tenant #2 and felt as the only caregiver in the unit she could not leave the tenants unattended. Video footage showed

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Staff L went to the front of the memory care unit, she called out for assistance to Staff M and reported a tenant exited through a stairwell door. Staff D overheard the request for assistance and went outside to search. Staff M notified leadership staff. Upon return to the unit, Tenant #2 was assessed and had no injuries. Tenant #2 had a known history of wandering and exit seeking behaviors.

Staff statements provided by the Program include the following:

a. Staff B indicated she and Staff C completed a count at 3:00 p.m. and everyone was there. After Staff B and Staff C left Staff L and went upstairs to the game. When they left, they made sure Staff L was with them. Tenant #2 was with them.

b. Staff C indicated at the 3:00 p.m. check Tenant #2 was in his room, watching a movie. Staff L was in the living room with the rest of the tenants with a snack and drink. Staff L was the one who was staying with them.

c. Staff L indicated she was in the living room with 11 tenants. It was happy hour, she passed drinks and cookies. Staff L then administered medication to a tenant. On her way to that tenant, she heard an alarm. She was not sure which door but did not see anyone at the front door. She went to check the back door and some tenants indicated it was Tenant #2 that went out. Staff L went to the front desk and asked for help then ran back to the memory care unit. Staff L indicated she was alone and could not go look for him.

d. Staff M indicated at about 3:35 p.m. Staff L came to the front desk and reported Tenant #2 had gotten outside of memory care. She thought

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he went down the stairs and got outside. Staff D was also at the front desk and left for the exit door from the memory area to the outside. Staff M went outside and walked towards the wooded area. Staff M messaged the leadership staff that he had gotten outside. Staff M went to memory care and at that time the Executive Director walked towards and she reported Tenant #2 had been found upstairs.

e. Staff D indicated at about 3:30 p.m. Staff D was at the front desk talking to Staff M. Staff L came out of memory care door and told them Tenant #2 left through the side door. Staff D indicated she was going to the garage to look for him. Staff D did not see him and ran back to the front desk. Staff D saw staff walking with him towards memory care.

Further record review on 3/26/26 of Tenant #2's file revealed Tenant #2 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. The service plan dated 11/19/25 reflected Tenant #2 had a history of wandering, entering other tenant's apartments and exit seeking. The service plan was updated to reflect Tenant #2 exited the building on 11/27/25 and 12/18/25.

2. When interviewed on 3/31/26 at 10:52 a.m. Staff B said she was working with Staff C and Staff L. After rounds were completed, there was something upstairs for Christmas. She said rounds were finished, everyone was toileted and there was nothing to do. Staff B and Staff C went upstairs. Staff B said she did not know two people had to stay on the floor. Staff L was told they were going upstairs and said okay. After a couple of minutes, the door opened upstairs and Tenant #2 was outside of the activity room on second floor.

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Staff B, Staff C and another staff brought him back to memory care. It was about five to eight minutes from when they left until when Tenant #2 was seen on the second floor. The Executive Director came and talked to staff. Staff B was suspended for the night. Staff B indicated she did not know two were needed in the unit at all times. Tenant #2 was not outside of the building but was outside of the unit. All staff now had walkie talkies. Tenant #2 was redirectable to the unit.

When interviewed on 4/1/26 at 10:10 a.m. Staff C reported Staff B and Staff C completed rounds. Staff L was doing an activity with tenants. Staff B and Staff C left to go to the assisted living (general population). They completed rounds and then left. After that staff indicated he was found walking and had left memory care. Before she was not aware there could only be one person, after that she was aware two to three people in memory care. Tenant #2 did not have any injuries.

When interviewed on 4/1/26 at 10:45 a.m. Staff L reported she worked with two other staff on second shift that day, including Staff C. She could not recall the other staff's name. There were three staff assigned. There was a Christmas Party. Staff L took over the activity and about 4:00 p.m. she started to prepare medications for one of the tenants. She heard an alarm, looked at the front door. There was no one there and turned then saw two tenants and saw the stairwell door close. The tenants indicated it was Tenant #2. Staff L tried to call the assisted living phone and there was no answer. Staff L opened the front door and screamed to the reception area (Staff D and Staff M) that Tenant #2 was out. They left running. She was told he was on the steps, coming up to the party. Staff L saw the other staff,

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Staff B and Staff C, coming back and forth and at that time no one else was in the unit.

When interviewed on 3/31/26 at 1:27 p.m. Staff D reported it was the holiday party and Staff D came in for the party was not working. When done at the party, she stopped to talk to Staff M. Staff L flew the memory care door open and said Tenant #2 was out. Staff D went to check the garage and went through the storage areas. Staff D came back up and went to the second floor. Someone was walking towards the room where the party was at with Tenant #2. Two staff punched in for work at 2:00 p.m., went to report and went to the party. Staff L was by herself. She indicated Staff M also started looking for Tenant #2.

When interviewed on 3/31/26 at 4:00 p.m. Staff M reported Staff L came up while Staff M and Staff D were talking. Staff L indicated Tenant #2 was not in memory care. Staff D left and went looking and Staff M sent a text message to leadership staff and she left to check the wooded area to the north. There was a holiday party going on upstairs. Tenant #2 came back with the Executive Director. He was in the assisted living hallway.

When interviewed on 4/1/26 at 2:30 p.m. the Assistant Director of Nursing (ADON) indicated all staff were there. Tenant #2 went to the stairwell and went upstairs. The ADON was helping at the party and saw him walking on the second floor. The Executive Director ran to him right away. Tenant #2 was assisted back to the unit. Tenant #2 did not leave the building and did not sustain any injuries. He set off the door alarm, two staff were supposed to be there with the third person. Staff L was in the unit and Staff B and Staff C were gone. Staff L did not let anyone know that

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she was the only person and she did not ask for help. Staff L saw him go up the stairwell but could not leave the unit. Staff L notified Staff M and Staff D overhead assistance was needed. Leadership staff found Tenant #2 before they were notified that he was gone. When the elopement occurred Staff B and Staff C returned to the unit and after the elopement they returned again to the party and were sent home. The ADON indicated she would have liked Staff L to reach out sooner. It was required three staff at all times on first and second shifts. She indicated staff were aware in training of the expectation.

When interviewed on 4/1/26 at 3:51 p.m. the Director of Nursing (DON) reported it sounded like Tenant #2 pressed through the side door. Staff L saw the door close and Staff B and Staff C had stepped out to the party. It was realized Tenant #2 had gotten out and that Staff B and Staff C were there. The Executive Director saw Tenant #2 down the second floor hallway. Tenant #2 left the unit but did not leave the building. He did not have any injuries. He indicated staffing in the unit was two to three depending on breaks or shifts. It was a minimum of two staff. Staff L had not called and leadership staff was not aware they were gone. He indicated regarding staffing expectations, it was gone over verbally and only one person could leave the unit at a time. He said Staff C was suspended related to the incident.

When interviewed on 4/1/26 at 1:01 p.m. the Executive Director indicated there was a Christmas party later in the afternoon. The Executive Director looked down the hallway and saw Tenant #2 on second floor. She went right to him and asked what he was doing. Tenant #2 indicated he was looking for the Executive Director. She saw him coming off the stairs onto

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A 325	Continued From page 24 the second floor. Tenant #2 was agreeable to return to the memory care unit. He did not leave the building and did not sustain any injuries. It was determined he pushed the side door; the alarm went off and two staff were at the party. One staff (Staff L) could not leave the unit but she did respond to the alarm. Staff D and Staff M helped search. 3. Observation on 3/31/26 at 11:47 a.m. the stairwell door exited to the stairwell that went upstairs to the second floor (general population) or went downstairs to an exterior door. That door went to the outside of the building. 4. Record review on 3/26/26 of Disciplinary Action Notice indicated Staff B and Staff C received a written warning and suspension on 12/18/25. It was noted they left the memory unit for an extended period of time, which left one staff to monitor the tenants. It was noted to ensure communication when leaving the unit, for two people to remain on the unit. Record review on 3/24/26 of the Program's staffing policy and procedure indicated sufficient trained staff would be provided to meet tenants identified needs.	A 325		
A 420	481-67.19(3)d Record Checks 67.19(3)d If a person considered for employment has a record of founded child abuse or dependent adult abuse. If a department of human services child or dependent adult abuse record check shows that a person being considered for employment in a program has a record of founded child or dependent adult abuse, the department of human services shall	A 420		

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A 420	Continued From page 25 notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of employment in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to request the department of human services perform an evaluation to determine if a found child abuse record prohibited the staff's employment (Staff A). Finding follows: Record review on 3/23/26 and 3/30/26 of Staff A's training documents revealed a hire date of 10/2/25. A Single Contact & License Background (SING) check was completed on 9/19/25. The background check indicated no records found for the dependent adult abuse registry and to start the record check process for the child abuse registry. The criminal history background check indicated further research and on 9/24/25 it returned and indicated no record was found. An evaluation determination was not completed for child abuse registry prior to Staff A's employment or at the time of the review. Continued record review on 3/30/26 of Staff A's background check information. A Iowa SING Result Summary was completed on 3/23/26 and the results indicated no record found for the dependent adult abuse registry, further research on the criminal background check and to initiate a record check evaluation process for the child abuse registry. The Record Check Evaluation dated 3/25/26 indicated Staff A could not work for the Program.	A 420		

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A 420	Continued From page 26 Further record review revealed Staff A was terminated on 3/27/26 due to the background check being denied by Iowa Regulatory Standards. The date Staff A last worked was 3/22/26. When interviewed on 4/1/26 at 1:01 p.m. the Executive Director confirmed Staff A did not have an evaluation prior to hire. Staff A was terminated as it did not align with background checks. Staff A was no longer employed as of 3/27/26.	A 420		
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 failed to develop service plans that reflected the service needs of the tenants. This pertained to 4 of 5 current tenant files reviewed (Tenant #1, #3, #4 and #5) and 1 of 1 discharged tenant reviewed (Tenant C1). Findings follow: 1. Record review on 3/26/26 of Tenant #1's file	A 350		

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A 350	Continued From page 27	A 350		

revealed an incident report indicated on 10/28/25 at 6:30 p.m. Tenant #1 eloped. On 10/28/25 at 5:42 p.m. Tenant #1 attempted to leave memory care and was redirected. At 5:46 p.m. Tenant #1 set off the door alarm and he was redirected with staff resetting the door alarm. Staff started an activity at 5:50 p.m. and Tenant #1 participated. He was observed by the Director of Nursing (DON) at 6:15 p.m. He participated in the activity for 33 minutes. Tenant #1 stood up, walked to the exit door and pushed through the door at 6:24 p.m. Tenant #1 was observed by Staff E at the front desk standing near the front door at 6:25 p.m. Staff E was intimidated by Tenant #1's size and went to get Staff F to help redirect him. Tenant #1 left the building at 6:25 p.m. Staff E and Staff F left the building at 6:26 p.m. At 6:27 p.m. Tenant #1 came back into the building with Staff E and Staff F. He went back to memory care at 6:28 p.m. A door alarm check was completed on all doors. It was determined the main door alarm was not armed at the time Tenant #1 left the memory care unit.

Continued record review revealed Tenant #1's service plan was updated on 10/28/25 and exit seeking was added. The service plan reflected Tenant #1 had a history of wandering, entering other tenant's apartments and exit seeking. The service plan was updated; however, did not reflect Tenant #1 had eloped from the memory care unit and from the building.

Further record review revealed Progress Notes indicated the following:

-On 3/11/26 communication was received on 3/8/26 and 3/10/26 regarding Tenant #1 needed the assistance of two to three people with standing.

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A 350	Continued From page 28 -On 3/18/26 communication was received on 3/17/26 regarding Tenant #1 needed two to three people with standing and he resisted more. -On 3/22/26 a nurse assessed Tenant #1 on 3/21/26 and 3/22/26, he had been having difficulty ambulating and going from sitting to standing. -On 3/24/26 staff communication was received on 3/20/26 regarding Tenant #1 required the assistance of two (plus) people. -On 3/25/26 communication was received on 3/23/26 regarding Tenant #1 transferred with assistance of three (plus) to get into bed. The nurse completed an assessment today and he transferred with stand by assistance out of his chair. Continued record review revealed Tenant #1's service plan updated on 3/24/26 reflected moderate transfer assistance and he might try to get up on his own. Staff was to encourage Tenant #1 to ask for assistance when needed. The service plan was updated however, did not reflect at times Tenant #1 required additional assistance with transfers as noted above. 2. Record review on 3/26/26 of Tenant #3's file revealed the January, February and March Monthly Task Logs reflected bathing refusals. Continued record review revealed Tenant #3's service plan reflected staff provided moderate assistance with bathing twice weekly. The service plan did not reflect Tenant #3's bathing refusals and interventions. Further record review revealed Progress Notes	A 350		

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A 350	Continued From page 29 indicated the following: -On 2/9/26 a care conference was held and safety concerns related to exit seeking were discussed. There was a discussion regarding a caregiver Monday through Friday mornings when she tended to exit seek. -On 2/27/26 a call was made to Tenant #3's power of attorney (POA) regarding if they added additional hours/days to the private duty caregiver. It was noted the private duty caregiver had not been seen that week. -On 3/6/26 Tenant #3's POA was called and told that caregivers were needed seven days per week during daytime hours related to exit seeking behaviors. -On 3/8/26 a voicemail was left for Tenant #3's POA that caregivers were needed seven days per week to continue to stay at the Program. -On 3/8/26 Tenant #3's POA stopped in and there was a care conference. The POA reported not being able to find individuals and asked for a company that provided private duty care. A company name was provided to the POA. The need for caregivers seven days per week from 9:00 a.m. to 4:00 p.m. was discussed. The POA also wanted to try medications. -On 3/18/26 Tenant #3's POA met with the Executive Director and was issued a 30-day notice. The POA offered to provide a caregiver daily for six hours. Continued record review revealed Tenant #3's service plan did not reflect the private caregiver's hours provided.	A 350		

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A 350	Continued From page 30 3. Record review on 3/26/26 and 3/30/26 of Tenant #4's file revealed an incident report indicated on 10/10/25 at 7:15 p.m. Tenant #4 was found in another tenant's apartment on the bed. The incident report indicated Tenant #4 was removed from the apartment. The DON and POA were notified. Continued record review revealed staff statements were collected by the Program for the 10/10/25 incident and indicated the following: Staff B's statement indicated the last time she saw Tenant #4 was at 6:00 (p.m.) in the television room. When Staff B went to her apartment about 7:00 p.m. she was not in her apartment. Staff B let the staff know, staff started looking for her and Staff D found Tenant #4 in with Tenant C1. Staff C's statement indicated she completed rounds and saw them on the bed. The male tenant told Staff C "she's my wife." Staff C thought they were going to sleep. "I just said good night to them." Staff D's statement indicated at about 7:00 p.m. Staff D was informed by one of the staff that one of the tenants was missing. Staff D directed the staff to complete a search at the front while Staff D started rounds. Staff D found Tenant #4 on the bed in a male tenant's apartment. Continued record review of Tenant #4's file revealed Progress Notes indicated the following: -On 10/13/25 a fax was sent to the primary care provider (PCP) related to the incident on 10/10/25. The on-call nurse was notified on 10/10/25 that staff could not find Tenant #4 at	A 350		

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about 7:15 p.m. and started a search. Tenant #4 was located in another tenant's apartment. Staff observed the other tenant, nude and on top of Tenant #4 in the bed. Tenant #4 was fully clothed and no "penetration occurred." No harmful acts were completed to Tenant #4. When assessed on 10/13/25, Tenant #4 was doing well and had no concerns. Staff would be reeducated on elopement procedures and hourly rounds.

-On 10/15/25 the male tenant was fully nude and Tenant #4 was fully clothed. Staff reported Tenant #4 had pants on and no signs of disheveled clothing. There were no indicators or reports of "penetration from female resident." The families of both tenants were notified and fax was sent to Tenant #4's PCP.

Further record review revealed Tenant #4 service plan was updated after the incident on 10/10/25; however, it was not updated until 10/16/26. It reflected a current or history of occasional disruptive, aggressive, sexual advances or socially inappropriate behavior. It was noted Tenant #4 had a history of sexual advances with male tenants and Tenant #4 allowed to hold hands with another tenant (not Tenant C1) as both families had given permission. The service plan did not reflect the incident that occurred between Tenant #4 and Tenant C1 and interventions.

4. Record review on 3/30/26 of Tenant #5's file revealed the February and March 2026 medication administration records (MARs) revealed at times Tenant #5 refused medications.

Observation on 3/25/26 at the time of lunch time medication pass revealed Tenant #5 refused the initial attempt from staff to administer her

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A 350	Continued From page 32 medications. When interviewed on 3/25/26 at 1:33 p.m. Staff N indicated Tenant #5 yelled at staff to leave her alone. She would strike towards staff. Staff N indicated when Tenant #5 was like that staff tried an approach of good cop, bad cop. When interviewed on 3/25/26 at 1:44 p.m. Staff O reported Tenant #5 had behaviors towards staff. They tried good cop, bad cop with her. Continued record review of Tenant #5's service plan reflected that staff administered her medications, she tended to chew her medications and medications could be crushed as needed. The service plan reflected Tenant #5 did not have any behavior issues. The service plan did not reflect Tenant #5's medication refusals, her behavior and any interventions deemed appropriate related to behaviors. Further record review revealed Progress Notes indicated the following: -On 1/30/26 a fax was sent to the PCP regarding redness under her left breast. It was warm and tender to the touch. -On 2/1/26 a new order was received to have family take her to urgent care. -On 2/1/26 Tenant #5 returned from urgent care with orders for Keflex 500 milligram (mg), one capsule three times daily for seven days. Clotrimazole 1% cream, apply under the left breast twice daily for 14 days. -On 2/4/26 a change of condition was updated for a diagnosis of cellulitis.	A 350		

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A 350	Continued From page 33 -On 2/19/26 a fax was sent to the PCP on 2/16/26 the Clotrimazole external cream under the left breast was discontinued after 14 days. The area was still pink under breast fold. Some yeast was still present. An order was requested to restart the Clotrimazole cream under the left breast until healed. -On 3/5/26 the area under the left breast was healed. -On 3/13/26 it was noted on 3/12/26 Tenant #5 was walking and fell face first, she was sent to the hospital and returned. She sustained a right eye bruise, left eye bruise and mouth skin tear. Tenant #5 had a service plan that reflected fall history. -On 3/26/26 staff called the nurse and reported Tenant #5 fell and was bleeding from her forehead. Family declined to have Tenant #5 sent out. Continued record review revealed Tenant #5's service plan, updated on 2/4/26 reflected a diagnosis of cellulitis and a history of skin impairment. The service plan was not specific to Tenant #5's affected area of the skin impairment. The service plan also reflected Tenant #5 had falls; however, provided standard fall interventions and not specific to Tenant #5's falls. 5. Record review on 3/30/26 of Tenant C1's file revealed an incident report indicated on 10/10/25 at 7:15 p.m. Tenant C1 was found in his apartment with a female tenant. The DON was notified. Continued record review revealed staff	A 350		

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statements were collected by the Program for the 10/10/25 incident and indicated the following:

Staff B's statement indicated the last time she saw Tenant #4 was at 6:00 (p.m.) in the television room. When Staff B went to her apartment about 7:00 p.m. she was not in her apartment. Staff B let the staff know, staff started looking for her and Staff D found Tenant #4 in with Tenant C1.

Staff C's statement indicated she completed rounds and saw them on the bed. The male tenant told Staff C "she's my wife." Staff C thought they were going to sleep. "I just said good night to them."

Staff D's statement indicated at about 7:00 p.m. Staff D was informed by one of the staff that one of the tenants was missing. Staff D directed the staff to complete a search at the front while Staff D started rounds. Staff D found Tenant #4 on the bed in a male tenant's apartment.

Further record review of Tenant C1's file revealed Progress Notes indicated the following:

-On 10/13/25 it was noted on 10/10/25 the on-call nurse was notified Tenant C1 was in his apartment with another tenant. Staff found Tenant C1 nude and on top of the other tenant when in bed. Tenant C1 did not perform any acts to harm the other tenant. The other tenant was fully clothed and was removed from the apartment.

-On 10/13/25 staff reported on 10/12/25 he had increased incontinence, pinched a staff's breasts and tried to grab between staff's legs.

Continued record review revealed Tenant C1's service plan, updated on 10/13/25 reflected he

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A 350	Continued From page 35 had a history of occasional disruptive, aggressive or socially inappropriate behavior. He was known to kiss, grope, show affection, expose himself with female tenants and sexual advances. Staff was to remove him from the situation and notify the nurse. The service plan did not reflect the incident that occurred between Tenant C1 and Tenant #4. When interviewed on 4/2/26 at 1:42 p.m. the DON said Tenant #1 was not using a walker anymore and confirmed the finding related to Tenant #1's service plan with transfer assist. He said regarding Tenant #3, it did have a caregiver listed and the hours varied. They asked for 9 a.m. to 4 p.m. and it fluctuated sometimes two to three hours. He confirmed it was not on the service plan. He confirmed service plans were not specific to the incident for Tenant #4 and Tenant C1. He confirmed the finding related to Tenant #5's service plan.	A 350		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to have an operating door alarm. This pertained to 1 of 2 tenants reviewed that had eloped (Tenant #1). Finding follows: 1. Record review on 3/26/26 revealed an incident	A 635		

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A 635	Continued From page 36	A 635		

report indicated on 10/28/25 at 6:30 p.m. Tenant #1 eloped. On 10/28/25 at 5:42 p.m. Tenant #1 attempted to leave memory care and was redirected. At 5:46 p.m. Tenant #1 set off the door alarm and he was redirected with staff resetting the door alarm. Staff started an activity at 5:50 p.m. and Tenant #1 participated. He was observed by the Director of Nursing (DON) at 6:15 p.m. He participated in the activity for 33 minutes. Tenant #1 stood up, walked to the exit door and pushed through the door at 6:24 p.m. Tenant #1 was observed by Staff E at the front desk standing near the front door at 6:25 p.m. Staff E was intimidated by Tenant #1's size and went to get Staff F to help redirect him. Tenant #1 left the building at 6:25 p.m. Staff E and Staff F left the building at 6:26 p.m. At 6:27 p.m. Tenant #1 came back into the building with Staff E and Staff F. He went back to memory care at 6:28 p.m. A door alarm check was completed on all doors. It was determined the main door alarm was not armed at the time Tenant #1 left the memory care unit.

Continued record review revealed an Incident Investigation Report dated 10/29/25 indicated on 10/28/25 at 6:23 p.m. Tenant #1 was seen in the assisted living lobby by staff. The investigative conclusion indicated it was determined the DON had reset the door alarm when it was set off earlier. Tenant #1 pushed the door open at 6:24 p.m., the door did not alarm but the devices went off and one of the staff on duty cleared the alarm and Tenant #1 walked to the lobby. All staff were verbally educated at the time that they were not to clear an alarm on the device without going to the door. Staff E was educated on not leaving tenants unattended.

Further record review revealed staff statements

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(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 635	Continued From page 37 provided by the Program indicated the following: -The DON's statement indicated he was working in the memory care kitchen and showed Tenant #1 and other tenants, pictures of puppies at about 6:15 p.m. The DON went back to work on his computer and at about 6:28 p.m. he heard the door open and Staff E indicated Tenant #1 had gotten out. The DON did not see Tenant #1 walk past him in the kitchen when going to the door. At 5:45 p.m. the DON stopped Tenant #1 from going and had to turn the alarm on the door off and back on with a key. -Staff E's statement indicated she saw a man walk in front of the reception desk and she asked if he was Tenant #1's first name. He did not verbally respond. He was slowly walking towards the exit. Staff E ran to the kitchen, opened the door and told Staff F she needed him now. She ran to the doorway and to the parking area with Staff F close behind her. Tenant #1 was attempting to open a passenger side door of a mini-van in the parking lot. Staff E and Staff F redirected Tenant #1 back into the building and walked him back to memory care. The DON and staff were shocked to see them bringing Tenant #1 back. -Staff F's statement indicated at 6:14 p.m. Tenant #1 was outside next to a car. Staff E ran to get Staff F and asked if he was a memory care tenant. Staff E and Staff F went to get him and get him back inside. -Staff G's statement indicated she last saw Tenant #1 at the activity in the television room. He stood up in the middle of the song and she thought he was walking around. Staff G did not hear an alarm when she was standing in the	A 635		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0445	A. BUILDING: _____ B. WING _____	C 04/02/2026

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A 635	Continued From page 38	A 635		

television room. The next thing, Staff E and Staff F brought Tenant #1 back to memory care. Staff G noticed the circle on the door was green and not red, that was why Staff G believed staff did not hear an alarm.

Further record review on 3/26/26 of Tenant #'1's file revealed he was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. He had moved into the Program on 10/6/25.

2. When interviewed on 4/1/26 at 3:51 p.m. the DON indicated at the time of the elopement Tenant #1 was new. Tenant #1 set off the door alarm and the DON thought he had reset the alarm. He went back to the table and looked at his computer, one staff came back to get help and reported Tenant #1 was out front. Tenant #1 was outside at the front entrance. He was agreeable to return. He completed a quick assessment of him and brought him back to a chair. He had no injuries. He was on a mission to go for a walk. No door alarms went off and the DON did not have a phone. It was figured out what happened with the door alarm. All staff, including himself, were educated on the door alarm.

When interviewed on 3/31/26 at 4:42 p.m. Staff E reported she looked up from the desk and Tenant #1 was a step and half from the front door. She thought it was Tenant #1. He walked slowly. Staff E knew Staff F was there and ran to get him. Staff E indicated she knew Tenant #1 could not get too far. Staff E and Staff F went outside and he was in the parking lot and with his hand on a passenger side door. He was right outside from the doors. Staff E indicated she spoke softly to him, called him by name, told him it was

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A 635	Continued From page 39	A 635		

sprinkling and he needed to get inside. Staff F spoke up and asked him to come inside with them. Staff walked him back to memory care and the staff was shocked and indicated he had just sat down to watch television. She reported the whole incident was two minutes from when he left to when he was brought back. He was dressed appropriately. Staff E reported no door alarms went off and if they were going off she would have heard them at the desk. She indicated staff were also surprised, which would account for the fact there was not an alarm. Since that time an emergency pendant was installed at the front desk and now there were walkie talkies. Staff E indicated there was a light sprinkle and it was at twilight.

When interviewed on 3/31/26 at 1:57 p.m. Staff F reported Staff E came and got him and said someone went out the door. He never met Tenant #1 before. Tenant #1 was outside pulling on a van door. Staff E and Staff F found him there. He had a shirt and shorts on. He walked by himself. Tenant #1 was agreeable to come back inside. He had no injuries. Staff F indicated it occurred on second shift, it was dark outside.

When interviewed on 3/31/26 at 3:15 p.m. Staff G reported she worked second shift as the medication aide. She saw Staff E and Staff F brought Tenant #1 back to the unit around 7:00 p.m. She indicated Staff E got Staff F to help as she was intimidated by Tenant #1's size and they got him back to the unit. Staff G last saw Tenant #1 walking, but he was not walking by the door. Staff G said there was no door alarm and nothing on the phones that the door had been opened. Staff G was not sure how long he was gone, she said Tenant #1 did not have any injuries. Staff G was not sure if Tenant #1 got outside but

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A 635	Continued From page 40	A 635		

indicated he walked towards the door. She reported the green light was on the door, Tenant #1 must have walked out and staff did not hear it.

When interviewed on 4/1/26 at 2:30 p.m. the Assistant Director of Nursing indicated the elopement with Tenant #1 happened after she had left. The DON was still there. Tenant #1 went to the general population lobby, went outside to the sidewalk. Staff E and Staff F went outside to get him. The door alarm was not alarmed correctly at the front entrance.

When interviewed on 4/1/26 at 1:01 p.m. the Executive Director indicated Tenant #1 got out because the door was not locked properly. It did not turn red and was not armed. The DON previously disarmed it. Tenant #1 did not have any injuries related to the elopement. Staff E was re-educated to keep eyes on him. A pendant was put at the front desk for emergency situations and the front desk staff had walkie talkies. Staff were shown how to disarm/arm the door.

3. When observed on 3/31/26 at approximately 9:35 a.m. the Program had multiple doors including two exit doors that had delayed egress and were armed doors. The doors went from the memory care to the general population and the stairwell door went to the second floor (assisted living) or to the lower level, which exited outside. The front door when opened sent an alert to the phone (door alarm was not set off). The stairwell door was set off and it alarmed; however, there was no message sent to the staff's phone regarding the door alarm. The door alarm functioned; however, the alert was not sent to staff's phone.

Weather conditions at the time of the elopement

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A 635	Continued From page 41 were provided by the State Climatologist on 4/1/26. The weather conditions in Coralville on 10/28/25 at 6:30 p.m. were as follows: Temperature: 52 degrees, relative humidity was 50%, winds were out of the northeast at 8 miles per hour, overcast conditions with light rain in the evening. Observation on 3/31/26 at 11:47 a.m. revealed the possible area Tenant #1 traveled to the memory care entrance door then went to the hallway in the general population section of the building. There was a front desk area and lobby area at the end of the hallway. Near the lobby was an interior door that went to the vestibule then another door that went to the exterior of the building. The parking area was located next to the building.	A 635		

STIRLINGSHIRE
DIAL SENIOR LIVING

Plan of Correction for Stirlingshire of Coralville MC
In Response to
Stirlingshire of Coralville (ALP/D) Recertification, Investigations #130582-C, #130776-I, #130914-I and #131096-I
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 the alarmed door policy, incident report policy, ADL documentation.
2. **What measures will be taken to ensure the problem does not recur.**
    a. The DON/ADON or designee will routinely review staff 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: 481-67.3(2) Tenant Rights
481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate.

1. **Elements detailing how the program will correct the insufficiency.**
    a. Tenant C1 moved out of the community on 10/26/25
2. **What measures will be taken to ensure the problem does not recur.**
    a. Tenant C1 moved out of the community on 10/26/25.
    b. Education provided to nursing staff regarding notification of the nurse of all romantic relationships/interactions between residents.
3. **How the program plans to monitor performance to ensure compliance.**

a. Regional nurse or designee will periodically audit nursing notes and incident reports to ensure compliance

4. **The date by which the regulatory insufficiency will be corrected.**
    a. This regulatory insufficiency will be corrected by 5/28/2026

Regulatory Insufficiency: 481-67.9(1) 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.

1. **Elements detailing how the program will correct the insufficiency.**
    a. DON and/or designee will provide re-education to all direct care nursing staff regarding staff leaving the secured unit together and communication with one another.
2. **What measures will be taken to ensure the problem does not recur.**
    a. DON or designee will periodically observe staffing numbers to ensure compliance.
3. **How the program plans to monitor performance to ensure compliance.**
    a. Regional Nurse and/or designee will periodically visit community and observe staffing patterns and numbers to ensure compliance.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. This regulatory insufficiency will be corrected by 5/28/2026.

Regulatory Insufficiency: 481-67.19(3)d Record Checks

67.19(3)d 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 C 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: 81-69.26(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, #3, #4, and #5 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.

<u>Regulatory Insufficiency</u>: 481-69.32(2) Life Safety - Emergency Policies / Structure

69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.

1. **Elements detailing how the program will correct the insufficiency.**
    a. Floor staff and DON were re-educated on the properly arming and disarming alarmed doors in memory care on 10/28/2025
2. **What measures will be taken to ensure the problem does not recur.**
    a. The ED, DON, ADON, and/or designee will randomly check alarmed doors for proper functioning 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

Sincerely,

Amy Kubik-Hasley, Executive Director