Iowa Department of Inspections, Appeals, and Licensing
Health & Safety Division
Adult Services Civil Penalty Citation

Date: August 5, 2026
Program Name: Lawton Senior Living
Address: 200 E Char-Mac Drive, Lawton, IA 51030
Type of Action: Investigations #131512-C, 131673-C, 131861-C, 131862-C, 131865-I, 131875-C, 131876-I, 131903-C, 132144-I, & 132174-C
Date(s) of Action: 4/9/26 - 8/5/26
Citation #11204

State Rule #		Amount of Civil Penalty
Iowa Administrative Code 481 Chapter 67.2(2)	**67.2(2) The program shall follow the policies and procedures established by the program.** Based on interview and record review, the program failed to consistently implement established policies and procedures regarding tenant health and safety. Findings follow: Record review on 06/29/26 revealed the program's Fall Prevention and Reduction policy (dated 02/25/25) directed staff to immediately notify the nurse, primary care provider, and power of attorney (POA) following a fall. The policy further directed staff to obtain a current set of vital signs and inspect the resident's skin and pain level. Upon instruction from the nurse, two staff members were to assist the resident using a mechanical lift or non-emergency services as needed. The policy also required documentation of the fall and monitoring of the resident's condition for 72 hours. Record review on 05/05/26 revealed Tenant #C1's incident report dated 04/04/26, which indicated a call was received at 9:28 p.m. reporting Tenant #C1 had two skin tears on her left arm and bruising on her right bicep. A Resident Aide indicated the tenant may have had an unwitnessed fall on a previous shift. Continued record review revealed Tenant #C1's hospital records documented she arrived at the emergency room by ambulance on 04/06/26. She presented with multiple wounds, including bruises and skin tears in the following areas: anterior upper left leg; right pretibial; anterior left proximal upper left leg; posterior right lower arm; left upper face; left posterior hand; anterior right leg; anterior right knee; and left posterior arm (which had four skin	**$10,000.00**

	tears, the largest measuring approximately three inches). Tenant #C1's CT scans indicated she sustained multiple fractured ribs, a buckle fracture in the mid-sternum area, and a nondisplaced avulsion fracture in the upper hip bone (iliac wing). Record review on 06/23/26 revealed Tenant #C1's autopsy report, dated 04/23/26. The report noted she was 88 years old and listed her cause of death as unknown, with other significant conditions including: blunt force trauma with head and neck contusions; deep scalp hemorrhage; bilateral rib fractures; contusions, lacerations, and abrasions of the upper extremities; contusions of the lower extremities; bronchopneumonia; atherosclerotic cardiovascular disease; Alzheimer's disease; and a history of protein-calorie malnutrition. Specific findings included a 9x3 centimeter (cm) area of purple-red contusions on the left cheek, a 1x1 cm deep scalp hemorrhage on the left frontal area, mobile rib fractures on the right lateral 7th through 11th ribs and left lateral 3rd through 5th and 7th through 10th ribs, and immobile rib fractures on the left posterior 3rd through 5th ribs. Additional record review revealed Client #C1, 88 years old, had diagnoses including, but not limited to: unspecified dementia, unsteadiness on feet, anxiety disorder (unspecified), insomnia. Tenant #C1's most recent service plan, dated 10/30/25, noted interventions for falls included: If tenant appears unsteady/dizzy, encourage tenant to sit down; encourage/frequently remind resident to ask for assistance when attempting to sit or stand; staff to assist resident in restroom in case of syncopal episode. The service plan further noted Tenant #C1 required minimal assistance with mobility and may require prompts/cues for safety. The plan further noted she utilized a gait belt and walker. During an interview on 06/26/26 at 8:15 a.m., Staff G, a minor, reported he worked alone in the memory care unit with 10 tenants during the 2:00 p.m. to 10:00 p.m. shift on 04/03/26. He stated he got Tenant #C1 out of bed to eat, but she did not eat well. He then had her get up from her chair to walk to the bathroom using her walker while he trailed a step or two behind her. Staff G reported as Tenant #C1 crossed the transition strip from the carpet to the tile, the ski of her walker caught, causing her to trip. She reached for the sink/counter to catch herself, fell to the floor on her right side, and landed on top of her walker. Staff G indicated he checked her quickly; she was not making sounds or speaking. He got behind her, placed his arms under her armpits, and pulled her up. He noted she was difficult to lift but not too heavy. He grabbed her walker, which she held onto, and walked her back to bed without	

	using the toilet. She then went to sleep. Staff G confirmed he did not contact a nurse or document Tenant #C1 had fallen. During an interview on 07/16/26 at 2:14 p.m., the Regional Director of Operations confirmed staff failed to follow the fall prevention policy by failing to report the fall to the nurse. 2. Record review on 05/29/26 revealed the program's Incident Report policy (dated 05/15/24), which instructed staff to notify the nurse or designee if a resident fell or if any unusual event occurred. An incident form was to be completed by the Registered Nurse (RN) or designee for documentation purposes. The policy further instructed incident reports must be factual, concise, signed, and dated with the time of completion by the writer, and accompanied by factual statements from any witnesses. a. Record review on 05/05/26 revealed Tenant #C1's incident report dated 04/04/26. The report noted the incident occurred at 6:00 p.m. and recorded a call received at 9:28 p.m. reporting Tenant #C1 had two skin tears on her left arm and bruising on her right bicep. The Resident Aide noted the tenant may have had an unwitnessed fall on a previous shift. Staff N reported the incident. The section of the incident report designated for witness statements was left completely blank. Continued record review revealed hospital records showing Tenant #C1 arrived at the emergency room by ambulance on 04/06/26, with multiple bruises and skin tears across her body, as well as multiple rib fractures, a mid-sternum buckle fracture, and an avulsion fracture of the hip. During an interview on 05/19/26 at 5:47 a.m., Staff H stated she worked the overnight shift from 04/03/26 to 04/04/26. Staff G gave report to Staff H, stating Tenant #C1 was in bed and doing okay. When Staff H performed rounds, she observed Tenant #C1 touching her arm. Although it was dark, Staff H noticed blood coming from the wrist area. Staff H wiped the arm and covered it with Tenant #C1's sleeve, assuming the tenant was picking at her skin. Staff H noted when she later assisted Tenant #C1 to the bathroom, she recalled seeing an older bruise, but had not worked in a while and thought nothing of it. She noted there was no blood soaking through the sleeve. Staff H observed Tenant #C1 acted unusually during toilet assistance-normally she stood up quickly while still urinating, but this time she moved differently. Staff H reported the bruising to incoming Staff V during shift change. Staff H stated because no nurse was on duty during her shift, staff	

	simply passed concerns to the incoming shift rather than contacting the triage nurse. She confirmed she did not report the cut or bruise to the triage nurse. On 05/13/26 at 12:55 p.m., Staff E reported being present when the marks on Tenant #C1 were identified. On 05/22/26 at 11:22 a.m., Staff I stated she viewed the skin tears and bruising when Staff N asked her to look. On 07/16/26 at 2:14 p.m., the Regional Director of Operations confirmed an incident report was not completed until 04/04/26 at 6:00 p.m. She indicated no witness statements were included until the program conducted its internal investigation, acknowledging she was unaware assisted living regulations required witness statements to be submitted with incident reports.	
481-67.3(2)	**481-67.3(231B,231C,231D) Tenant rights. All tenants have the following rights:** **67.3(2) To receive care, treatment and services that are adequate and appropriate.** Based on interview and record review, the program failed to provide adequate and appropriate care, treatment, and services. Findings follow: Record review on 5/05/26 revealed Tenant #C1's incident report dated 4/04/26 indicated a call received at 9:28 p.m. Tenant #C1 had two skin tears of left arm and bruising on her right bicep. The Resident Aide indicated the patient may have had an unwitnessed fall on previous shift. Continued record review revealed Tenant #C1's hospital record indicated she arrived by ambulance on 4/06/26 to the emergency room. She presented with multiple wounds of bruises and skin tears included the following areas of her body: anterior upper left leg; right pretibial; anterior left proximal upper left leg; posterior right lower arm; left upper face; left posterior hand; anterior right leg; anterior right knee; left posterior arm with four skin tears the largest approximately three inches. Tenant #C1's CT scans indicated she sustained multiple fractured ribs, a buckle fracture in the mid sternum area, and a nondisplaced avulsion fracture in the upper/largest part of the hip bone.	

	Tenant #C1 was discharged to a different facility and passed away 4/22/26. Record review revealed Client #C1, 88 years old, had diagnoses including, but not limited to: unspecified dementia, unsteadiness on feet, anxiety disorder (unspecified), insomnia. Tenant #C1's most recent service plan, dated 10/30/25, noted interventions for falls included: If tenant appears unsteady/dizzy, encourage tenant to sit down; encourage/frequently remind resident to ask for assistance when attempting to sit or stand; staff to assist resident in restroom in case of syncopal episode. The service plan further noted Tenant #C1 required minimal assistance with mobility and may require prompts/cues for safety. The plan further noted she utilized a gait belt and walker. Record review on 6/23/26 revealed Tenant #C1's autopsy report, dated 4/23/26, indicated she was 88 years old and her cause of death was unknown. The report indicated other significant conditions included: blunt force trauma: head and neck contusions; deep scalp hemorrhage; bilateral rib fractures, contusions, lacerations, and abrasions of the upper extremities; and contusions of the lower extremities; bronchopneumonia; atherosclerotic cardiovascular disease; Alzheimer disease; and history of protein calorie malnutrition. The findings included a nine by three-centimeter (cm) area of multiple purple-red contusions on the left cheek, a one by one cm left frontal deep scalp hemorrhage, mobile rib fractures on the right lateral ribs seven through eleven, mobile rib fractures on the left lateral ribs three through five and seven through ten, and immobile rib fractures on the left posterior ribs three through five. When interviewed on 5/12/26 at 4:20 p.m. Tenant #C1's Power of Attorney (POA) reported the Program contacted her first around 10-10:30 a.m. on 4/06/26. The Health Care Coordinator contacted the POA reporting she received a call Tenant #C1 fell, however when the HCC looked at it she thought it was more than a fall. The HCC indicated she would call the POA when she knew more. The POA reported she received a call around 2-2:30 p.m. from the HCC indicating it was a lot worse than she thought. The POA went to the Program. When she arrived at the Program, the HCC and the RSC were in her mother's room. They indicated it was not another tenant that hurt Tenant #C1, it was a male worker. The POA asked her mother who hurt her. The POA indicated her mother spoke in the clearest voice that day and responded that a man hurt her and he needed to be put in jail. The POA indicated she saw the bruising on the tenant's legs and hips, also the skin tears on her arm. The HCC called the ambulance and notified law enforcement. The POA	

	did not receive a phone call over the weekend about her mother and hospice did not receive a call either. The POA did not understand why the Program took so long to call an ambulance for her mother. When interviewed on 5/26/26 at 4:11 p.m. the Triage Registered Nurse (RN) indicated she received a call on 4/04/26. The Triage RN was not able to complete an assessment on Tenant #C1 as she was over the phone. She indicated since Tenant #C1 was on hospice Tenant #C1 would be seen by the hospice nurse for an assessment. However, Tenant #C1's chart lacked the phone number for her hospice provider. The Triage RN called twice for the hospice number she found online. She never followed up further to ensure Hospice assessed Tenant #C1. The Triage RN indicated Tenant #C1 needed further evaluation. She also indicated she did not know Tenant #C1's baseline. When interviewed on 5/11/26 at 4:38 p.m. the Hospice nurse reported she saw Tenant #C1 on 4/06/26 after the Health Care Coordinator (HCC) called around 10:00 a.m. concerned about Tenant #C1, she felt like it did not add up to a fall with all the bruising. The Hospice Nurse saw Tenant #C1's bruise on her arm, face and the skin tears. She reported Tenant #C1 had a slight limp when she ambulated approximately six feet and sat in the chair. The Hospice Nurse was unable to look at the bruising on the lower half of her body due to Tenant #C1 not wanting to ambulate to the bathroom. She indicated to the HCC it could not have been an unwitnessed fall as Tenant #C1 was unable to get herself up off the floor. The Hospice Nurse indicated no one from the Program had contacted the on-call nurse for the hospice agency, they checked their records. The Hospice Nurse indicated if they were contacted they would have come out and evaluated Tenant #C1 especially after she found out Tenant #C1 did not get out of bed all weekend. When interviewed on 5/15/26 at 10:59 a.m. the Primary Care Provider (PCP) indicated when she arrived the HCC and the Regional Nurse Specialist were present in the room. The PCP saw the right arm bruise and other bruises scattered over her body. The bruises were deep purple, yellow and greenish. The PCP was contacted on 4/6/26 by the HCC. A follow up interview on 5/20/26 at 10:22 a.m. indicated the Hospice Nurse had already been at the Program for Tenant #C1. The PCP left the Program around 1:57 p.m. Tenant #C1 had not gone to the hospital. When interviewed on 6/26/26 at 8:15 a.m. Staff G, a minor, reported he worked the 2:00p.m. to 10:00p.m. shift on 4/03/26 in	

	the memory care unit by himself with ten tenants. He reported he got Tenant #C1 out of bed to eat. She did not eat well. Staff G had Tenant #C1 to get up from the chair to go to the bathroom. She walked with her walker to the bathroom. Staff G indicated he was a step or two behind Tenant #C1. He reported Tenant #C1 went over the transition piece from the carpet to the tile and got the ski of her walker caught. Tenant #C1 tripped and tried to catch herself as she reached for the sink/counter. Staff G reported she fell to the floor on her right side and her walker was under her. He indicated he checked her quickly and she was not making sounds or saying anything. Staff G reported he got behind her and got her situated to get his arms under her armpits. He indicated she was not easy to pick up but not too heavy. He grabbed her walker and she grabbed onto it. He reported she did not use the toilet, he walked with her back to her bed. She went to lay in her bed. Staff G reported she slept. He did not contact a nurse or document Tenant #C1 fell. He indicated he did not know what to do and he did not know what the triage number was until his mom told him what it was. She did not use the bathroom for the shift. She also did not eat well. When interviewed on 5/19/26 at 5:47 a.m. Staff H indicated she worked the overnight shift on 4/03/26 to 4/04/26. Staff G gave Staff H report and indicated Tenant #C1 was in her bed and okay. Staff H went to complete rounds. She saw Tenant #C1 touched her arm. It was dark in her room, however she saw blood coming out of her arm area by the wrist. Staff H wiped Tenant #C1's arm and covered the area with her sleeve. Staff H thought Tenant #C1 was digging at her arm. Staff H indicated when she took her to the bathroom, she recalled an older bruise on Tenant #C1 but Staff H had not worked in awhile and thought nothing of it. Staff H indicated there was no bleeding through Tenant #C1's sleeve. Staff H recalled she helped Tenant #C1 up and to the toilet. She assisted Tenant #C1 with wiping. Staff H indicated Tenant #C1 acted differently than how she usually was quick to stand up and still be urinating. According to Staff H, she reported it to Staff V who came in for the next shift about Tenant #C1's bruise. Staff H indicated the shift reported concerns to the next shift since there was no nurse on her shift. She did not report the cut or bruise to the triage nurse. When interviewed on 6/25/26 at 11:10 a.m. Staff V indicated one staff worked in the memory care unit. Staff V reported he regularly had difficulty getting Tenant #C1 up from bed. Tenant #C1 would continue to lay in her bed when he tried to get her up for the bathroom, to change her, or to eat. Staff V recalled he worked the	

	whole day on 4/04/26. Tenant #C1 laid in bed during the shift. He recalled telling law enforcement he did not change or feed Tenant #C1; however, he did remember feeding her. Staff V reported he saw a big bruise on Tenant #C1's arm. He assumed it was an injury another staff had done an incident report for. Staff V did not call the Triage Nurse, however he saw the large purple bruise when Staff N found it. When interviewed on 5/19/26 at 11:10 a.m. Staff T reported she worked on 4/05/26 with Tenant #C1 who lay in bed during her shift. Tenant #C1 was talkative. She said she was going to sue the Program and call the police. Tenant #C1 also stated she needed to go to the hospital as she lay in bed. Staff T noticed skin tears on her arm when she changed her in bed because Tenant #C1 did not get up for the bathroom. She recalled Tenant #C1 had a lot of purple and red bruises on her legs. She also reported Tenant #C1 did not eat. Staff T did not report to the nurse since Staff N indicated it was reported the day before. Staff T indicated there were not staff to nurse communication logs on Tenant #C1's care. When interviewed on 6/12/26 at 9:03 a.m. the Resident Services Coordinator (RSC) reported he worked on 4/04/26 with Staff V who worked in the memory care unit. The RSC indicated they were short staffed due to a call in from what he recalled. Staff V did not ask for assistance with Tenant #C1. After the RSC left work, he recalled a phone call around 9:00p.m. from staff who asked if Tenant #C1 had an unwitnessed fall. The RSC was unaware of a fall and Staff E reported Tenant #C1 had some bruising and a skin tear on her arm. The RSC instructed staff to call the triage nurse as the Regional Nurse Specialist told him not to contact the HCC for nursing issues. The RSC worked the next day on 4/05/26 and recalled only seeing a mark on the side of her head below the temple area. He did not hear anything different from the triage report from the night before except to keep an eye on changes for her. He saw Tenant #C1 walking; however, she was not making as many trips up the hallway. The RSC indicated he worked on 4/06/26. Staff told the HCC Tenant #C1 would not take her shower. The RSC and the HCC went down to Tenant #C1's room to assist. The RSC reported Tenant #C1 was in her room and she was hesitant and flinched getting out of bed. The RSC and the HCC helped Tenant #C1 into a sitting position on the bed. The RSC reported the HCC was concerned with getting her into the shower. He recalled the skin tear on her arm, spot on her temple and bruises on her hip and knees. The RSC tidied Tenant #C1's room while the HCC showered her. He indicated Tenant #C1 ambulated slower than usual. The RSC reported Tenant #C1 was verbal	

	indicating she fell a couple of weeks ago when asked. Tenant #C1 also verbalized a boy, when asked if someone hurt her. When interviewed on 6/11/26 at 1:03 p.m. the Health Care Coordinator (HCC) indicated she worked on 4/06/26 and came into the office and reviewed emails. She reviewed the incident reports and went to check Tenant #C1 after it was reported as an unwitnessed/undocumented fall. When the HCC arrived Tenant #C1 was in her bed. The HCC pulled back her sleeve to find several skin tears appeared like nail scratches. Tenant #C1's other hand was more contracted which did not make sense to be her own nails. The skin tears appeared fresh. She also had bruises on the same side of her skin tears. The bruise on her arm was dark purple approximately the size of a grape fruit. When the HCC and RSC wanted to help sit Tenant #C1 up she jumped as if someone was going to hurt her. While in the shower, the HCC noted Tenant #C1's sternum had a yellow bruise, smaller bruises on her inner thighs, bruises on the outer knee and inside of the ankles, a bruise on the top of her head, and a bruise on her hip. When she was ready to walk out of the bathroom Tenant #C1 verbalized "ow" and "asprin." Tenant #C1 verbalized yes when asked if someone hurt her and when asked who did it, she responded with a boy. The HCC indicated the daughter made the decision to send Tenant #C1 into the emergency room. When interviewed on 6/03/26 at 12:08 p.m., the Triage Coordinator indicated the coordinator scheduled the triage nurse, completed training with the triage nurse, and the coordinator took questions. According to the Triage Coordinator, the triage nurse found the hospice number as one of the tenant's contacts in their electronic health record (EHR). The Triage Coordinator confirmed in Tenant #C1's EHR, the hospice provider, was not listed as a contact in her record. The Coordinator further indicated the triage nurse was trained to contact hospice if the tenant needed further evaluation since the triage nurse was not able to complete a full assessment. According to the Coordinator, the triage nurse needed to call hospice back in 20-30 minutes until contact was made. If the tenant needed further assessment then the nurse contacted the family or emergency services to get a further evaluation. The Coordinator indicated the Triage Nurse should have followed the Clinical Communication Hierarchy. When interviewed on 7/16/26 at 2:14 p.m. the Regional Director of Operations confirmed staff and the Triage Nurse failed to get Tenant #C1 the appropriate treatment and care faster than 4/06/26.	

	When interviewed on 7/9/26 at 1:30 p.m. the State Medical Examiner (SME) confirmed Tenant #C1 passed 4/22/26 and her autopsy was conducted 4/23/26. He confirmed he could not determine the cause of death, but noted it was likely due to a confluence of all noted significant contributing factors (blunt force trauma, bronchopneumonia, atherosclerotic cardiovascular disease, Alzheimer disease, and history of protein calorie malnutrition). He explained while the tenant was noted to have multiple injuries on 4/6/26 when arriving at the hospital, there was likely healing that occurred. The SME confirmed Tenant #C1 sustained multiple fractured ribs, including mobile fractures (fracture caused bones to move or shift against each other, causing pain and instability) to ribs 7-11 on the right side and ribs 3-4 and 7-10 on the life side. He also noted immobile fractures of ribs 3-5 on the left side. He stated the rib fractures increased the tenant's risk for pneumonia (a significant cause of death noted in the autopsy). The SME further stated the rib fractures were present laterally (side) and posteriorly (back), and noted it was possible the fractures could have been the result of compression or squeezing. He added it was unlikely a fall to the right side (as reported) would cause injuries to the left side of the body.	
481-67.9(2)	**481-67.9(231B,231C,231D) Staffing.** **67.9(2) Emergency procedures. All program staff shall be able to implement the accident, fire safety, and emergency procedures.** Based on interview and record review, the Program failed to implement emergency procedures regarding clinical communication hierarchy and fall prevention and reduction. Findings follow: Record review on 5/05/26 revealed Tenant #C1's incident report dated 4/04/26, which documented a call received at 9:28 p.m. Tenant #C1 had two skin tears of the left arm and bruising on her right bicep. The Resident Assistant (RA) indicated the patient may have had an unwitnessed fall on the previous shift. Tenant #C1 had a full range of motion of upper and lower extremities. The RA cleaned the skin tear site with soap and water and applied an appropriate dressing. The RA monitored Tenant #C1 after staff advised the RA to call triage with any changes in injury or condition. The report indicated staff contacted the Power of Attorney on 4/06/26.	

	Continued record review revealed Tenant #C1's hospital record indicated she arrived by ambulance on 4/06/26 to the emergency room. She presented with multiple wounds of bruises and skin tears including the following areas of her body: anterior upper left leg; right pretibial; anterior left, proximal upper left leg; posterior right lower arm; left upper face; left posterior hand; anterior right leg; anterior right knee; left posterior arm with four skin tears, the largest approximately three inches. Tenant #C1's CT scans indicated she sustained multiple fractured ribs, a buckle fracture in the med sternum area, and a nondisplaced avulsion fracture in the upper/largest part of the hip bone. Record review on 6/23/26 revealed Tenant #C1's autopsy report dated 4/23/26, which indicated she was 88 years old and her cause of death was unknown. The report indicated other significant conditions included blunt force trauma, bronchopneumonia, atherosclerotic cardiovascular disease, Alzheimer disease, and history of protein calorie malnutrition. The findings included a nine by three-centimeter (cm) area of multiple purple-red contusions on the left cheek, a one by one cm left frontal deep scalp hemorrhage, mobile rib fractures on the right lateral ribs seven through eleven, mobile rib fractures on the left lateral ribs three through five and seven through ten, and immobile rib fractures on the left posterior ribs three through five. Record review on 6/22/26 revealed the Program policy, Falls Prevention and Reduction dated 2/2025. This policy indicated that if a fall occurred, staff must perform timely notification of the nurse, the resident's primary care provider (PCP), and the responsible party/Power of Attorney. After staff document a fall, staff should monitor the resident's condition for 72 hours or until injuries or complaints resolve. When interviewed on 6/26/26 at 8:15 a.m. Staff G, a minor, reported he worked the 2:00 p.m. to 10:00 p.m. shift on 4/03/26 in the memory care unit by himself with ten tenants. He reported he got Tenant #C1 out of bed to eat. She did not eat well. Staff G had Tenant #C1 to get up from the chair to go to the bathroom. She walked with her walker to the bathroom. Staff G indicated he was a step or two behind Tenant #C1. He reported Tenant #C1 went over the transition piece from the carpet to the tile and got the ski of her walker caught. Tenant #C1 tripped and tried to catch herself as she reached for the sink/counter. Staff G reported she fell to the floor on her right side and her walker was under her. He indicated he checked her quickly and she was not making sounds	

	or saying anything. Staff G reported he got behind her and got her situated to get his arms under her armpits. He indicated she was not easy to pick up but not too heavy. He grabbed her walker and she grabbed onto it. He reported she did not use the toilet, he walked with her back to her bed. She went to lay in her bed. Staff G reported she slept. He did not contact a nurse or document Tenant #C1 fell. He indicated he did not know what to do and he did not know what the triage number was until his mom told him what it was. She did not use the bathroom for the shift. She also did not eat well. When interviewed on 6/12/26 at 9:03 a.m. the Resident Services Coordinator (RSC) reported he worked on 4/04/26 with Staff V who worked in the memory care unit. The RSC indicated they were short staffed due to a call in. He recalled Staff V did not ask for assistance with Tenant #C1. After the RSC left work, he received a phone call around 9:00 pm from Staff who asked if Tenant #C1 had an unwitnessed fall. The RSC was unaware of a fall and Staff E reported Tenant #C1 had some bruising and a skin tear on her arm. The RSC instructed staff to call the triage nurse as the Regional Nurse Specialist told him not to contact the HCC for nursing issues. The RSC worked the next day on 4/05/26 and recalled only seeing a mark on the side of her head below the temple area. He did not hear anything different from the triage report from the night before except to keep an eye on changes for her. He saw Tenant #C1 walking; however, she was not making as many trips up the hallway. When interviewed on 7/16/26 at 2:14 p.m. the Regional Director of Operations confirmed the staff failed to follow the fall policy. 2. Record review on 6/22/26 revealed the Program policy, Clinical Communication Hierarchy, dated 12/19/23, indicated staff contacted the Triage Nurse from 7:00 pm to 7:00 am on Monday through Friday and 24 hours a day on Saturday and Sunday. The hierarchy indicated the point of contact starting with the Triage Nurse then to escalate up to Jaybird Senior Living Director of Clinical Operations. The policy indicated contact must be made by phone. Text messages, voicemail, emails were not sufficient substitutes. a. When interviewed on 5/26/26 at 4:11 p.m. the Triage Registered Nurse (RN) indicated she received a call on 4/04/26. The Triage RN was not able to complete an assessment on Tenant #C1 as she was over the phone and out of state. She indicated that since Tenant	

	#C1 was on hospice, the hospice nurse would perform an assessment. However, Tenant #C1's chart lacked the phone number for her hospice provider. The Triage RN called twice for the hospice number she found by searching online. She never followed up further to ensure the Hospice nurse assessed Tenant #C1. The Triage RN indicated Tenant #C1 needed further evaluation. She also indicated she did not know Tenant #C1's baseline. The Triage RN did not call the Power of Attorney. She indicated she was not allowed to call the community nurse when the Triage Nurse was on-call. When interviewed on 6/03/26 at 12:08 p.m., the Triage Coordinator indicated the coordinator scheduled the triage nurse, completed training with the triage nurse, and the coordinator took questions. According to the Triage Coordinator, the triage nurse found the hospice number as one of the tenant's contacts in their electronic health record (EHR). The Triage Coordinator confirmed that Tenant #C1's EHR did not list the hospice provider as a contact in her record. The Triage Coordinator further indicated staff trained the triage nurse to contact hospice if the tenant needed further evaluation since the triage nurse was not able to complete a full assessment. According to the Triage Coordinator, the triage nurse needed to call hospice back every 20-30 minutes until she made contact. If the tenant needed further assessment, then the nurse contacted the family or emergency services to get a further evaluation. The Triage Coordinator indicated the triage nurse should have followed the Clinical Communication Hierarchy. When interviewed on 7/16/26 at 2:14 p.m. the Regional Director of Operations acknowledged the Triage Nurse failed to follow established policy. If she would have known more about the incident, they could have acted faster. When interviewed on 7/9/26 at 1:30 p.m. the State Medical Examiner (SME) confirmed Tenant #C1 passed 4/22/26 and her autopsy was conducted 4/23/26. He confirmed he could not determine the cause of death, but noted it was likely due to a confluence of all noted significant contributing factors (blunt force trauma, bronchopneumonia, atherosclerotic cardiovascular disease, Alzheimer disease, and history of protein calorie malnutrition). He explained while the tenant was noted to have multiple injuries on 4/6/26 when arriving at the hospital, there was likely healing that occurred. The SME confirmed Tenant #C1 sustained multiple fractured ribs, including mobile fractures (fracture caused bones to move or shift against each other, causing pain and instability) to ribs 7-11 on the right side and ribs 3-4 and	

	7-10 on the life side. He also noted immobile fractures of ribs 3-5 on the left side. He stated the rib fractures increased the tenant's risk for pneumonia (a significant cause of death noted in the autopsy). The SME further stated the rib fractures were present laterally (side) and posteriorly (back), and noted it was possible the fractures could have been the result of compression or squeezing. He added it was unlikely a fall to the right side (as reported) would cause injuries to the left side of the body. b. When interviewed on 5/19/26 at 11:10 a.m. Staff T reported she worked on 4/05/26 with Tenant #C1 who lay in bed during her shift. Tenant #C1 was talkative in her bed. Tenant #C1 stated she was going to sue the Program. She also stated she needed to call the police and go to the hospital as she lay in bed. Staff T noticed skin tears on her arm when she changed her in bed because Tenant #C1 did not get up for the bathroom. She recalled Tenant #C1 had a lot of purple and red bruises on her legs. She also reported Tenant #C1 did not eat. Staff T did not report to the triage nurse since she contacted Staff N via phone and she indicated it had been reported. When interviewed on 6/12/26 at 9:03 a.m. the Resident Services Coordinator (RSC) reported he worked on 4/05/26 and recalled only seeing a mark on the side of her head below the temple area. He did not report the mark to the Triage Nurse because he did not hear anything different from the triage report from the night before, which had only advised staff to keep an eye on changes for her.	
481-67.9(4)g	**481-67.9(231B,231C,231D) Staffing.** **67.9(4)Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall include the following:** **g. The program will have in place a system by which direct care staff communicate in writing occurrences that differ from the tenant's normal health and functional and cognitive status. The program's nurse or designee will train staff on reporting to the program's nurse(s) or designee(s) and documenting occurrences that differ from the tenant's normal health and functional and cognitive status. The written communication required by this paragraph will be retained by the program for a period of not less**	

	than three years and be accessible to the department upon request. Based on interview and record review, the program failed to ensure a system in place for direct care staff to communicate in writing occurrences in tenant conditions. Finding follows: See Iowa Administrative Code 481 Chapter 67.2(3) for additional information. Record review on 6/17/26 revealed the program's policy, Other Resident Occurrences - Staff Communication Form", dated 5/15/24, instructed program staff to use the Registered Nurse (RN) Communication Form to communicate to the RN, occurrences that differed from the tenant's normal health, functional, and cognitive status when the nurse was not present or available in person. The policy noted the written communication should be retained by the program for a period of not less than three years and should be available to the Department of Inspections and Appeals upon request. The policy instructed program staff communication was received by the nurse verbally and/or in person, the nurse or designee should document in the resident record as applicable. The policy further revealed program staff received training on resident concerns which required written notification to the Nurse. When interviewed on 5/19/26 at 5:47 a.m. Staff H indicated she worked the overnight shift on 4/03/26 to 4/04/26. Staff G gave Staff H report and indicated Tenant #C1 was in her bed and okay. When Staff H completed rounds, she saw Tenant #C1 touched her arm. It was dark in her room, however she saw blood coming out of her arm area by the wrist. Staff H wiped Tenant #C1's arm and covered the area with her sleeve. Staff H thought Tenant #C1 was digging at her arm. Staff H indicated when she took her to the bathroom, she recalled an older bruise on Tenant #C1, but Staff H had not worked in awhile and thought nothing of it. Staff H indicated there was no bleeding through Tenant #C1's sleeve. Staff H recalled she helped Tenant #C1 get up and to the toilet. She assisted Tenant #C1 with cleaning up after using the toilet and indicated Tenant #C1 acted differently. She was usually quick to stand up and often was still urinating. According to Staff H, she reported Tenant #C's bruise to Staff V who came in for the next shift. Staff H indicated the shift reported concerns to the next shift since there was no nurse on her shift. She did not report the cut or bruise to the triage nurse.	

	When interviewed on 6/25/26 at 11:10 a.m. Staff V indicated one staff was in the memory care unit. Staff V reported Tenant #C1 would not get up for him. Tenant #C1 continued to lay in her bed when he tried to get her up for the bathroom, to change her, or to eat. On 4/04/26, he worked the whole day. He recalled telling law enforcement he did not change or feed Tenant #C1;, however, he did remember feeding her. Staff V did not call the Triage Nurse, however he saw the large purple bruise when Staff N found it. When interviewed on 5/19/26 at 11:10 a.m. Staff T reported she worked on 4/05/26 with Tenant #C1 who lay in bed during her shift. Tenant #C1 was talkative in her bed. She said she was going to sue this place. She stated she would call the police and that she needed to go to the hospital as she lay in bed. Staff T noticed skin tears on her arm when she changed her in bed because Tenant #C1 did not get up for the bathroom. She recalled Tenant #C1 had a lot of purple and red bruises on her legs. She also reported Tenant #C1 did not eat. Staff T did not report to the nurse since Staff N indicated it was reported the day before. Staff T indicated there were not staff to nurse communication logs on Tenant #C1's care. Record review on 6/11/26 of staff communication to nurse logs revealed the earliest report noted by staff to the nurse on 4/14/26 in the log book. The Regional Nurse Specialist confirmed via email on 5/19/26 at 4:25pm no staff to RN forms could be located from the timeframe of 2/10/26 to 3/10/26. During an interview on 5/19/26 at 4:55pm, the Health Care Coordinator (HCC) indicated she inquired with upper management about written staff communication sheets. The HCC believed they may have existed before, but she had not seen evidence of forms on file. She provided education to staff about the forms and instructed staff to use them for occurrences in the building. She instructed staff to place them in her box. The HCC noted it may have been likely no system was in place prior to her employment, as she recalled she had shown program staff the forms and staff didn't know about the forms at all and questioned her on what the forms were.	

481-69.22(3)	**481-69.22(231C) Evaluation of tenant.** **69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation.** Record review on 5/05/26 revealed Tenant #C1's incident report dated 4/04/26 indicated a call received at 9:28 p.m. Tenant #C1 had two skin rears of left arm and bruising on her right bicep. The Resident Aide indicated the patient may have had an unwitnessed fall on previous shift. Continued record review revealed Tenant #C1's hospital record indicated she arrived by ambulance on 4/06/26 to the emergency room. She presented with multiple wounds of bruises and skin tears included the following areas of her body: anterior upper left leg; right pretibial; anterior left, proximal upper left leg; posterior right lower arm; left upper face; left posterior hand; anterior right leg; anterior right knee; left posterior arm with four skin tears the largest approximately three inches. Tenant #C1's CT scans indicated she sustained multiple fractured ribs, a buckle fracture in the med sternum area, and a nondisplaced avulsion fracture in the upper/largest part of the hip bone. Tenant #C1 was discharged to a different facility and passed 4/22/26. Record review revealed Client #C1, 88 years old, had diagnoses including, but not limited to: unspecified dementia, unsteadiness on feet, anxiety disorder (unspecified), insomnia. Tenant #C1's most recent service plan, dated 10/30/25, noted interventions for falls included: If tenant appears unsteady/dizzy, encourage tenant to sit down; encourage/frequently remind resident to ask for assistance when attempting to sit or stand; staff to assist resident in restroom in case of syncopal episode. The service plan further noted Tenant #C1 required minimal assistance with mobility and may require prompts/cues for safety. The plan further noted she utilized a gait belt and walker. Record review on 6/23/26 revealed Tenant #C1's autopsy report, dated 4/23/26, indicated she was 88 years old and her cause of death was unknown. The report indicated other significant conditions included: blunt force trauma: head and neck	

	contusions; deep scalp hemorrhage; bilateral rib fractures, contusions, lacerations, and abrasions of the upper extremities; and contusions of the lower extremities; bronchopneumonia; atherosclerotic cardiovascular disease; Alzheimer disease; and history of protein calorie malnutrition. The findings included a nine by three-centimeter (cm) area of multiple purple-red contusions on the left cheek, a one by one cm left frontal deep scalp hemorrhage, mobile rib fractures on the right lateral ribs seven through eleven, mobile rib fractures on the left lateral ribs three through five and seven through ten, and immobile rib fractures on the left posterior ribs three through five. When interviewed on 5/26/26 at 4:11 p.m. the Triage Registered Nurse (RN) indicated she received a call on 4/04/26. The Triage RN was not able to complete an assessment on Tenant #C1 as she was over the phone. She indicated since Tenant #C1 was on hospice Tenant #C1 would be seen by the hospice nurse for an assessment. However, Tenant #C1's chart lacked the phone number for her hospice provider. The Triage RN called twice for the hospice number she found online. She never followed up further to ensure Hospice assessed Tenant #C1. The Triage RN indicated Tenant #C1 needed further evaluation. She also indicated she did not know Tenant #C1's baseline. When interviewed on 6/26/26 at 8:15 a.m. Staff G, a minor, reported he worked the 2:00 p.m. to 10:00 p.m. shift on 4/03/26 in the memory care unit by himself with ten tenants. He reported he got Tenant #C1 out of bed to eat. She did not eat well. Staff G had Tenant #C1 to get up from the chair to go to the bathroom. She walked with her walker to the bathroom. Staff G indicated he was a step or two behind Tenant #C1. He reported Tenant #C1 went over the transition piece from the carpet to the tile and got the ski of her walker caught. Tenant #C1 tripped and tried to catch herself as she reached for the sink/counter. Staff G reported she fell to the floor on her right side and her walker was under her. He indicated he checked her quickly and she was not making sounds or saying anything. Staff G reported he got behind her and got her situated to get his arms under her armpits. He indicated she was not easy to pick up but not too heavy. He grabbed her walker and she grabbed onto it. He reported she did not use the toilet, he walked with her back to her bed. She went to lay in her bed. Staff G reported she slept. He did not contact a nurse or document Tenant #C1 fell. He indicated he did not know what to do and he did not know what the triage number was until his mom told him what it was. She did not use the bathroom for the shift. She also did not eat well.	

	When interviewed on 5/19/26 at 5:47 a.m. Staff H indicated she worked the overnight shift on 4/03/26 to 4/04/26. Staff G gave Staff H report and indicated Tenant #C1 was in her bed and okay. Staff H went to complete rounds. She saw Tenant #C1 touched her arm. It was dark in her room, however she saw blood coming out of her arm area by the wrist. Staff H wiped Tenant #C1's arm and covered the area with her sleeve. Staff H thought Tenant #C1 was digging at her arm. Staff H indicated when she took her to the bathroom, she recalled an older bruise on Tenant #C1 but Staff H had not worked in awhile and thought nothing of it. Staff H indicated there was no bleeding through Tenant #C1's sleeve. Staff H recalled she helped Tenant #C1 up and to the toilet. She assisted Tenant #C1 with wiping. Staff H indicated Tenant #C1 acted differently than how she usually was quick to stand up and still be urinating. According to Staff H, she reported it to Staff V who came in for the next shift about Tenant #C1's bruise. Staff H indicated the shift reported concerns to the next shift since there was no nurse on her shift. She did not report the cut or bruise to the triage nurse. When interviewed on 6/25/26 at 11:10 a.m. Staff V indicated one staff worked in the memory care unit. Staff V reported he regularly had difficulty getting Tenant #C1 up from bed. Tenant #C1 would continue to lay in her bed when he tried to get her up for the bathroom, to change her, or to eat. Staff V recalled he worked the whole day on 4/04/26. Tenant #C1 laid in bed during the shift. He recalled telling law enforcement he did not change or feed Tenant #C1; however, he did remember feeding her. Staff V reported he saw a big bruise on Tenant #C1's arm. He assumed it was an injury another staff had done an incident report for. Staff V did not call the Triage Nurse, however he saw the large purple bruise when Staff N found it. When interviewed on 5/19/26 at 11:10 a.m. Staff T reported she worked on 4/05/26 with Tenant #C1 who lay in bed during her shift. Tenant #C1 was talkative. She said she was going to sue the Program and call the police. Tenant #C1 also stated she needed to go to the hospital as she lay in bed. Staff T noticed skin tears on her arm when she changed her in bed because Tenant #C1 did not get up for the bathroom. She recalled Tenant #C1 had a lot of purple and red bruises on her legs. She also reported Tenant #C1 did not eat. Staff T did not report to the nurse since Staff N indicated it was reported the day before. Staff T indicated there were not staff to nurse communication logs on Tenant #C1's care.	

	When interviewed on 6/12/26 at 9:03 a.m. the Resident Services Coordinator (RSC) reported he worked on 4/04/26 with Staff V who worked in the memory care unit. The RSC indicated they were short staffed due to a call in from what he recalled. Staff V did not ask for assistance with Tenant #C1. After the RSC left work, he recalled a phone call around 9:00 pm from staff who asked if Tenant #C1 had an unwitnessed fall. The RSC was unaware of a fall and Staff E reported Tenant #C1 had some bruising and a skin tear on her arm. The RSC instructed staff to call the triage nurse as the Regional Nurse Specialist told him not to contact the HCC for nursing issues. The RSC worked the next day on 4/05/26 and recalled only seeing a mark on the side of her head below the temple area. He did not hear anything different from the triage report from the night before except to keep an eye on changes for her. He saw Tenant #C1 walking; however, she was not making as many trips up the hallway. The RSC indicated he worked on 4/06/26. Staff told the HCC Tenant #C1 would not take her shower. The RSC and the HCC went down to Tenant #C1's room to assist. The RSC reported Tenant #C1 was in her room and she was hesitant and flinched getting out of bed. The RSC and the HCC helped Tenant #C1 into a sitting position on the bed. The RSC reported the HCC was concerned with getting her into the shower. He recalled the skin tear on her arm, spot on her temple and bruises on her hip and knees. The RSC tidied Tenant #C1's room while the HCC showered her. He indicated Tenant #C1 ambulated slower than usual. The RSC reported Tenant #C1 was verbal indicating she fell a couple of weeks ago when asked. Tenant #C1 also verbalized a boy, when asked if someone hurt her. When interviewed on 6/11/26 at 1:03 p.m. the Health Care Coordinator (HCC) indicated she worked on 4/06/26 and came into the office and reviewed emails. She reviewed the incident reports and went to check Tenant #C1 after it was reported as an unwitnessed/undocumented fall. When the HCC arrived Tenant #C1 was in her bed. The HCC pulled back her sleeve to find several skin tears appeared like nail scratches. Tenant #C1's other hand was more contracted which did not make sense to be her own nails. The skin tears appeared fresh. She also had bruises on the same side of her skin tears. The bruise on her arm was dark purple approximately the size of a grape fruit. When the HCC and RSC wanted to help sit Tenant #C1 up she jumped as if someone was going to hurt her. While in the shower, the HCC noted Tenant #C1's sternum had a yellow bruise, smaller bruises on her inner thighs, bruises on the outer knee and inside of the ankles, a bruise on the top of her head, and a bruise on her hip. When she was ready to walk out of the bathroom Tenant #C1 verbalized "ow" and	

	"asprin." Tenant #C1 verbalized yes when asked if someone hurt her and when asked who did it, she responded with a boy. The HCC indicated the daughter made the decision to send Tenant #C1 into the emergency room. When interviewed on 7/9/26 at 1:30 p.m. the State Medical Examiner (SME) confirmed Tenant #C1 passed 4/22/26 and her autopsy was conducted 4/23/26. He confirmed he could not determine the cause of death, but noted it was likely due to a confluence of all noted significant contributing factors (blunt force trauma, bronchopneumonia, atherosclerotic cardiovascular disease, Alzheimer disease, and history of protein calorie malnutrition). He explained while the tenant was noted to have multiple injuries on 4/6/26 when arriving at the hospital, there was likely healing that occurred. The SME confirmed Tenant #C1 sustained multiple fractured ribs, including mobile fractures (fracture caused bones to move or shift against each other, causing pain and instability) to ribs 7-11 on the right side and ribs 3-4 and 7-10 on the life side. He also noted immobile fractures of ribs 3-5 on the left side. He stated the rib fractures increased the tenant's risk for pneumonia (a significant cause of death noted in the autopsy). The SME further stated the rib fractures were present laterally (side) and posteriorly (back), and noted it was possible the fractures could have been the result of compression or squeezing. He added it was unlikely a fall to the right side (as reported) would cause injuries to the left side of the body. When interviewed on 7/16/26 at 2:14 p.m. the Regional Director of Operations confirmed staff and the Triage Nurse failed to get Tenant #C1 the appropriate treatment and care faster than 4/06/26.	
481-69.26(4)c	**481-69.26(231C) Service plans.** **69.26(4) The service plan shall be individualized and indicate:** **c. The service provider(s), if other than the program;** **Based on interview and record review the Program failed to include the service provider for hospice care in the service plan. This affected 1 of 2 discharged tenants (Tenant #C1).** **Finding follows:** Record review on 5/05/26 revealed Tenant #C1's incident report dated 4/04/26 indicated a call received at 9:28 p.m. Tenant #C1	

	had two skin rears of left arm and bruising on her right bicep. The Resident Aide indicated the patient may have had an unwitnessed fall on previous shift. Continued record review revealed Tenant #C1's face sheet listed her pharmacy and four physicians with phone numbers. The face sheet failed to list her hospice provider and phone number. When interviewed on 5/26/26 at 4:11 p.m. the Triage Registered Nurse (RN) indicated she received a call on 4/04/26. The Triage RN was not able to complete an assessment on Tenant #C1 as she was over the phone. She indicated since Tenant #C1 was on hospice Tenant #C1 would be seen by the hospice nurse for an assessment. However, Tenant #C1's chart lacked the phone number for her hospice provider. The Triage RN called twice for the hospice number she found online. The Triage RN indicated Tenant #C1 needed further evaluation. When interviewed on 6/03/26 at 12:08 p.m., the Triage Coordinator indicated the coordinator scheduled the triage nurse, completed training with the triage nurse, and the coordinator took questions. The Coordinator indicated the triage nurse was trained to contact hospice if the tenant needed further evaluation since the triage nurse was not able to complete a full assessment. According to the Triage Coordinator, the triage nurse could find contact information for hospice as one of the tenant's contacts in their electronic health record (EHR). The Triage Coordinator confirmed in Tenant #C1's EHR, the hospice provider was not listed as a contact. When interviewed on 7/16/26 at 2:14 p.m. the Regional Director of Operations indicated the third party vendor, such as hospice, should be listed in the service plan.	
481-69.27(2)c	**481-69.27(231C) Nurse review.** **69.27(2) If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation:** **c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status;**	

	Based on interviews and record review, the Program failed to complete a timely assessment of a tenant following a significant change in health status to ensure appropriate referrals for care. Finding follows: 1. Record review on 5/05/26 revealed Tenant #C1's incident report dated 4/04/26 indicated a call received at 9:28 p.m. Tenant #C1 had two skin rears of left arm and bruising on her right bicep. The Resident Aide indicated the patient may have had an unwitnessed fall on previous shift. Staff N documented Tenant #C1's vital signs. The report included no further assessment. Additional record review revealed a Progress Note dated 4/5/26 at 2:39 a.m., completed by the Triage Registered Nurse (RN) documented a call received from staff at 9:28pm to report two skin tears on Tenant #C1's left arm and bruising on her right bicep noted upon rounds and assisting the tenant to bed. Staff stated the tenant may have had an unwitnessed fall on previous shift. The note further documented, "...Resident has full range of motion of upper and lower extremeties. (Staff) advise to clean skin tear site with soap and water and apply appropriate dressing. Two calls placed to hospice services listed in patient chart no answer at this time. Voicemail left with instructions to callback. (Staff) advise to monitor patient to call triage with any changes in patient injury or condition. Director/HCC made aware." The next progress note, documented on 4/6/26 at 9:00am by HCC indicated Tenant #C1 assessed after triage call due to possible unwitnessed/undocumented fall. Tenant #C1 had multiple bruises on her body and skin tears to her left forearm. Tenant #C1's family and physician were notified. Tenant #C1 was sent to the emergency room (ER) for further evaluation. Continued record review revealed a comprehensive assessment, dated 4/6/26, completed by the Health Care Coordinator. The assessment noted Tenant #C1's vitals: blood pressure 108/68, pulse 80, respirations 19, temperature 99.7 degrees Fahrenheit. The assessment further indicated the Vice President of Clinical Operations completed a skin evaluation and noted, "...bruising and skin tears... Erythema to third digit on right hand. Healing several bruises all over entire body (different stages) and 3 skin tears to left forearm... left forearm, 3 skin tears noted. Fully body comprehensive assessment completed by nurse with varying stages of healing bruising noted through assessment. Due to findings, family/provider update & ER evaluation recommended. Will update additionally based on ER findings/direction." The HCC	

	assessed pain and discomfort and noted, "... agitated facial expression, guarding, crying..." The HCC noted Tenant #C1 appeared unsteady and complained of some pain with walking. Record review revealed a hospice visit note, dated 4/6/26 at 10:10am documented three skin tears: left distal outer arm forearm/skin tear measuring 1 centimeter (cm)x0.3cm x0.001cm; left outer arm forearm/skin tear measuring 11cm x0.4cm x0.001cm; left proximal outer arm forearm/skin tear measuring 1.0cm x0.3cm x0.001cm. The note documented a pain assessment revealed occasional labored breathing and a short period of hyperventilation, occasional moan/groan, low level speech with a negative or disapproving quality, and facial grimacing. Tenant #C1 scored a 5/10 on the Pain Assessment in Advanced Dementia (PAINAD) Scale, indicating moderate pain. The Hospice Nurse documented, "...Patient has bruising and (skin tears) of unknown origin. Upin arrival patient in her room... Bruising reporte to left side of face, left hand, right hip, right upper arm, right lower arm, bilateral inner knees. (Skin tear) to left forearm x3... Asked patient to ambulate for further assessment. When patient stood she limped slightly on right leg. She ambulated a few steps and then sat in her recliner...Asked patient to let me help her stand to go to bathroom in an effort to assess right hip and knees. Patient would not let this nurse help her out of the chair and remained sitting. PAINAD 5. (HCC) reports she will finish her investigation and then will report the injuries. Educated (HCC) to have her staff call (hospice) anytime (an) injury or fall occurs as hospice was not notified until today." Continued record review revealed Tenant #C1's hospital record indicated she arrived by ambulance on 4/06/26 to the emergency room. She presented with multiple wounds of bruises and skin tears included the following areas of her body: anterior upper left leg; right pretibial; anterior left, proximal upper left leg; posterior right lower arm; left upper face; left posterior hand; anterior right leg; anterior right knee; left posterior arm with four skin tears the largest approximately three inches. Tenant #C1's CT scans indicated she sustained multiple fractured ribs, a buckle fracture in the med sternum area, and a nondisplaced avulsion fracture in the upper/largest part of the hip bone. Record review on 6/23/26 revealed Tenant #C1's autopsy report, dated 4/23/26, indicated she was 88 years old and her cause of death was unknown. The report indicated other significant conditions included: blunt force trauma: head and neck contusions; deep scalp hemorrhage; bilateral rib fractures,	

	contusions, lacerations, and abrasions of the upper extremities; and contusions of the lower extremities; bronchopneumonia; atherosclerotic cardiovascular disease; Alzheimer disease; and history of protein calorie malnutrition. The findings included a nine by three-centimeter (cm) area of multiple purple-red contusions on the left cheek, a one by one cm left frontal deep scalp hemorrhage, mobile rib fractures on the right lateral ribs seven through eleven, mobile rib fractures on the left lateral ribs three through five and seven through ten, and immobile rib fractures on the left posterior ribs three through five. When interviewed on 5/12/26 at 4:20 p.m. Tenant #C1's Power of Attorney (POA) reported the Program contacted her first around 10-10:30 a.m. on 4/06/26. The Health Care Coordinator contacted the POA reporting she received a call Tenant #C1 fell, however when the HCC looked at it she thought it was more than a fall. The HCC indicated she would call the POA when she knew more. The POA reported she received a call around 2-2:30 p.m. from the HCC indicating it was a lot worse than she thought. The POA went to the Program. When she arrived at the Program, the HCC and the RSC were in her mother's room. They indicated it was not another tenant that hurt Tenant #C1, it was a male worker. The POA asked her mother who hurt her. The POA indicated her mother spoke in the clearest voice that day and responded that a man hurt her and he needed to be put in jail. The POA indicated she saw the bruising on the tenant's legs and hips, also the skin tears on her arm. The HCC called the ambulance and notified law enforcement. The POA did not receive a phone call over the weekend about her mother and hospice did not receive a call either. The POA did not understand why the Program took so long to call an ambulance for her mother. When interviewed on 5/26/26 at 4:11 p.m. the Triage Registered Nurse (RN) indicated she received a call on 4/04/26. The Triage RN was not able to complete an assessment on Tenant #C1 as she was over the phone. She indicated since Tenant #C1 was on hospice Tenant #C1 would be seen by the hospice nurse for an assessment. However, Tenant #C1's chart lacked the phone number for her hospice provider. The Triage RN called twice for the hospice number she found online. She never followed up further to ensure Hospice assessed Tenant #C1. The Triage RN indicated Tenant #C1 needed further evaluation. She also indicated she did not know Tenant #C1's baseline. When interviewed on 5/11/26 at 4:38 p.m. the Hospice nurse reported she saw Tenant #C1 on 4/06/26 after the Health Care	

	Coordinator (HCC) called around 10:00 a.m. concerned about Tenant #C1, she felt like it did not add up to a fall with all the bruising. The Hospice Nurse saw Tenant #C1's bruise on her arm, face and the skin tears. She reported Tenant #C1 had a slight limp when she ambulated approximately six feet and sat in the chair. The Hospice Nurse was unable to look at the bruising on the lower half of her body due to Tenant #C1 not wanting to ambulate to the bathroom. She indicated to the HCC it could not have been an unwitnessed fall as Tenant #C1 was unable to get herself up off the floor. The Hospice Nurse indicated no one from the Program had contacted the on-call nurse for the hospice agency, they checked their records. The Hospice Nurse indicated if they were contacted they would have come out and evaluated Tenant #C1 especially after she found out Tenant #C1 did not get out of bed all weekend. When interviewed on 5/15/26 at 10:59 a.m. the Primary Care Physician (PCP) indicated when she arrived the HCC and the Regional Nurse Specialist were present in the room. The PCP saw the right arm bruise and other bruises scattered over her body. The bruises were deep purple, yellow and greenish. The PCP was contacted on 4/6/26 by the HCC. A follow up interview on 5/20/26 at 10:22 a.m. indicated the Hospice Nurse had already been at the Program for Tenant #C1. The PCP left the Program around 1:57 p.m. Tenant #C1 had not gone to the hospital. When interviewed on 6/26/26 at 8:15 a.m. Staff G reported he worked the 2:00 p.m. to 10:00 p.m. shift on 4/03/26 in the memory care unit by himself with ten tenants. He reported he got Tenant #C1 out of bed to eat. She did not eat well. Staff G had Tenant #C1 to get up from the chair to go to the bathroom. She walked with her walker to the bathroom. Staff G indicated he was a step or two behind Tenant #C1. He reported Tenant #C1 went over the transition piece from the carpet to the tile and got the ski of her walker caught. Tenant #C1 tripped and tried to catch herself as she reached for the sink/counter. Staff G reported she fell to the floor on her right side and her walker was under her. He indicated he checked her quickly and she was not making sounds or saying anything. Staff G reported he got behind her and got her situated to get his arms under her armpits. He indicated she was not easy to pick up but not too heavy. He grabbed her walker and she grabbed onto it. He reported she did not use the toilet, he walked with her back to her bed. She went to lay in her bed. Staff G reported she slept. He did not contact a nurse or document Tenant #C1 fell. He indicated he did not know what to do and he did not know what the triage number was until his mom told him what it	

	was. She did not use the bathroom for the shift. She also did not eat well. When interviewed on 5/19/26 at 5:47 a.m. Staff H indicated she worked the overnight shift on 4/03/26 to 4/04/26. Staff G gave Staff H report and indicated Tenant #C1 was in her bed and okay. Staff H went to complete rounds. She saw Tenant #C1 touched her arm. It was dark in her room, however she saw blood coming out of her arm area by the wrist. Staff H wiped Tenant #C1's arm and covered the area with her sleeve. Staff H thought Tenant #C1 was digging at her arm. Staff H indicated when she took her to the bathroom, she recalled an older bruise on Tenant #C1 but Staff H had not worked in awhile and thought nothing of it. Staff H indicated there was no bleeding through Tenant #C1's sleeve. Staff H recalled she helped Tenant #C1 up and to the toilet. She assisted Tenant #C1 with wiping. Staff H indicated Tenant #C1 acted differently than how she usually was quick to stand up and still be urinating. According to Staff H, she reported it to Staff V who came in for the next shift about Tenant #C1's bruise. Staff H indicated the shift reported concerns to the next shift since there was no nurse on her shift. She did not report the cut or bruise to the triage nurse. When interviewed on 6/25/26 at 11:10 a.m. Staff V indicated one staff worked in the memory care unit. Staff V reported he regularly had difficulty getting Tenant #C1 up from bed. Tenant #C1 would continue to lay in her bed when he tried to get her up for the bathroom, to change her, or to eat. Staff V recalled he worked the whole day on 4/04/26. Tenant #C1 laid in bed during the shift. He recalled telling law enforcement he did not change or feed Tenant #C1; however, he did remember feeding her. Staff V reported he saw a big bruise on Tenant #C1's arm. He assumed it was an injury another staff had done an incident report for. Staff V did not call the Triage Nurse, however he saw the large purple bruise when Staff N found it. When interviewed on 5/19/26 at 11:10 a.m. Staff T reported she worked on 4/05/26 with Tenant #C1 who lay in bed during her shift. Tenant #C1 was talkative. She said she was going to sue the Program and call the police. Tenant #C1 also stated she needed to go to the hospital as she lay in bed. Staff T noticed skin tears on her arm when she changed her in bed because Tenant #C1 did not get up for the bathroom. She recalled Tenant #C1 had a lot of purple and red bruises on her legs. She also reported Tenant #C1 did not eat. Staff T did not report to the nurse since Staff N	

	indicated it was reported the day before. Staff T indicated there were not staff to nurse communication logs on Tenant #C1's care. When interviewed on 6/12/26 at 9:03 a.m. the Resident Services Coordinator (RSC) reported he worked on 4/04/26 with Staff V who worked in the memory care unit. The RSC indicated they were short staffed due to a call in from what he recalled. Staff V did not ask for assistance with Tenant #C1. After the RSC left work, he recalled a phone call around 9:00 pm from staff who asked if Tenant #C1 had an unwitnessed fall. The RSC was unaware of a fall and Staff E reported Tenant #C1 had some bruising and a skin tear on her arm. The RSC instructed staff to call the triage nurse as the Regional Nurse Specialist told him not to contact the HCC for nursing issues. The RSC worked the next day on 4/05/26 and recalled only seeing a mark on the side of her head below the temple area. He did not hear anything different from the triage report from the night before except to keep an eye on changes for her. He saw Tenant #C1 walking; however, she was not making as many trips up the hallway. The RSC indicated he worked on 4/06/26. Staff told the HCC Tenant #C1 would not take her shower. The RSC and the HCC went down to Tenant #C1's room to assist. The RSC reported Tenant #C1 was in her room and she was hesitant and flinched getting out of bed. The RSC and the HCC helped Tenant #C1 into a sitting position on the bed. The RSC reported the HCC was concerned with getting her into the shower. He recalled the skin tear on her arm, spot on her temple and bruises on her hip and knees. The RSC tidied Tenant #C1's room while the HCC showered her. He indicated Tenant #C1 ambulated slower than usual. The RSC reported Tenant #C1 was verbal indicating she fell a couple of weeks ago when asked. Tenant #C1 also verbalized a boy, when asked if someone hurt her. When interviewed on 6/11/26 at 1:03 p.m. the Health Care Coordinator (HCC) indicated she worked on 4/06/26 and came into the office and reviewed emails. She reviewed the incident reports and went to check Tenant #C1 after it was reported as an unwitnessed/undocumented fall. When the HCC arrived Tenant #C1 was in her bed. The HCC pulled back her sleeve to find several skin tears appeared like nail scratches. Tenant #C1's other hand was more contracted which did not make sense to be her own nails. The skin tears appeared fresh. She also had bruises on the same side of her skin tears. The bruise on her arm was dark purple approximately the size of a grape fruit. When the HCC and RSC wanted to help sit Tenant #C1 up she jumped as if someone was going to hurt her. While in the shower, the HCC noted Tenant #C1's sternum had a yellow bruise, smaller bruises on her inner thighs,	

	bruises on the outer knee and inside of the ankles, a bruise on the top of her head, and a bruise on her hip. When she was ready to walk out of the bathroom Tenant #C1 verbalized "ow" and "asprin." Tenant #C1 verbalized yes when asked if someone hurt her and when asked who did it, she responded with a boy. The HCC indicated the daughter made the decision to send Tenant #C1 into the emergency room. When interviewed on 6/03/26 at 12:08 p.m., the Triage Coordinator indicated the coordinator scheduled the triage nurse, completed training with the triage nurse, and the coordinator took questions. According to the Triage Coordinator, the triage nurse found the hospice number as one of the tenant's contacts in their electronic health record (EHR). The Triage Coordinator confirmed in Tenant #C1's EHR, the hospice provider, was not listed as a contact in her record. The Coordinator further indicated the triage nurse was trained to contact hospice if the tenant needed further evaluation since the triage nurse was not able to complete a full assessment. According to the Coordinator, the triage nurse needed to call hospice back in 20-30 minutes until contact was made. If the tenant needed further assessment then the nurse contacted the family or emergency services to get a further evaluation. The Coordinator indicated the Triage Nurse should have followed the Clinical Communication Hierarchy. When interviewed on 7/9/26 at 1:30 p.m. the State Medical Examiner (SME) confirmed Tenant #C1 passed 4/22/26 and her autopsy was conducted 4/23/26. He confirmed he could not determine the cause of death, but noted it was likely due to a confluence of all noted significant contributing factors (blunt force trauma, bronchopneumonia, atherosclerotic cardiovascular disease, Alzheimer disease, and history of protein calorie malnutrition). He explained while the tenant was noted to have multiple injuries on 4/6/26 when arriving at the hospital, there was likely healing that occurred. The SME confirmed Tenant #C1 sustained multiple fractured ribs, including mobile fractures (fracture caused bones to move or shift against each other, causing pain and instability) to ribs 7-11 on the right side and ribs 3-4 and 7-10 on the life side. He also noted immobile fractures of ribs 3-5 on the left side. He stated the rib fractures increased the tenant's risk for pneumonia (a significant cause of death noted in the autopsy). The SME further stated the rib fractures were present laterally (side) and posteriorly (back), and noted it was possible the fractures could have been the result of compression or squeezing. He added it was unlikely a fall to the right side (as reported) would cause injuries to the left side of the body.	

	When interviewed on 7/16/26 at 2:14 p.m. the Regional Director of Operations confirmed staff and the Triage Nurse failed to get Tenant #C1 the appropriate treatment and care when she experienced a change in condition.	

Iowa Department of Inspections, Appeals, and Licensing
Health & Safety Division
Adult Services Civil Penalty Citation

481-67.3(1)	**481-67.3(231B,231C,231D) Tenant rights. All tenants have the following rights:** **67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy.** Based on observations, interview and record review the Program failed to ensure tenants were treated with consideration, respect, and full recognition of personal dignity and autonomy. This affected 4 of 9 tenants on the memory care unit (Tenant #2, Tenant #5, Tenant #6, Tenant #10) and potentially affected all tenants in the memory care unit. Finding follows: Observations on 5/5/26 at 5:13 p.m. revealed Staff L and Staff O present in the memory care unit. At 5:17 p.m., Staff L indicated Tenant #9, a male tenant displayed sexual behaviors with comments to the staff. Staff L indicated the Health Care Coordinator (HCC) directed staff to lock the tenants bedroom doors. At 5:57 p.m., the HCC entered the unit and told staff the tenants' doors needed to be locked. She also told staff to do their checks and watch. At 6:05 p.m., Staff P walked down the hallway and locked each tenant's door. At 6:15 p.m., Tenant #10 attempted to open his door to get in his apartment, but the handle did not move. Tenant #10 indicated he needed the bathroom. Tenant #10 walked down the hallway looking for a bathroom. Staff P told him he was going the wrong way. At 6:25 p.m., Tenant #5 slammed her walker down after she tried to open her door. Staff P asked if she needed her door unlocked to get in. Observations on 5/11/26 at 7:29 a.m. Staff R communicated with Staff H to lock Tenant #6's door since no staff were in the hallway and she was laying in bed. At 7:34 a.m., Staff R left Tenant #2's room and locked the door. At 7:38 p.m., Staff R indicated she locked the doors because only one staff and with Tenant #9's sexual behaviors needed to lock the doors. Record review on 6/10/26 revealed the Program policy, Resident Rights, dated 5/15/24, indicated the residents right to be treated with consideration, respect, and full recognition of personal dignity and autonomy. The policy also indicated residents to be free from restraint.	**$3500.00**

	When interviewed on 7/16/26 at 2:14 p.m. the Regional Director of Operations indicated it may potentially be a rights violation. She explained it can be a preference for the tenants to have their door locked. They were not able to be locked inside their room. She acknowledged it violated tenants' rights to be locked out of their rooms due to another tenant's behavior.	
481-69.22(3)	**481-69.22(231C) Evaluation of tenant.** **69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation.** Based on observations, interviews, and record review the Program failed to complete evaluations following significant change in tenant condition. Findings follow: Observations on 5/5/26 at 5:13 p.m. revealed Staff L and Staff O present in the memory care unit. At 5:17 p.m., Staff L indicated Tenant #9, a male tenant displayed sexual behaviors with comments to the staff. The Staff L indicated the Health Care Coordinator directed staff to lock the tenants bedroom doors. At 5:57 p.m., the HCC entered the unit and told staff the tenants' doors needed to be locked. She also told staff to do their checks and watch. At 6:05 p.m., Staff P walked down the hallway and locked each tenant's door. Record review revealed Tenant #9's incident report dated 5/5/26, indicated at 4:15 p.m. Tenant #9 asked staff for sexual behaviors. Continued record review revealed Tenant #9's Progress Notes included an entry by the HCC on 5/5/26. The notes indicated a call was made to the power of attorney (POA) following the tenant asking staff for sexual behaviors. An additional entry indicated a fax was sent to the primary care provider (PCP) about Tenant #9's behaviors. An entry on 5/6/26 noted a change of condition to the PCP regarding a change of behaviors.It further noted a message was left with the PCP. The new PCP was called and informed of his	

	behaviors and she noted she would look at his medication and see what to change. No additional entries were made in regards to the 5/5/26 follow up. When interviewed on 5/5/26 at 6:35pm Staff Q reported Tenant #9 displayed inappropriate sexual behavior towards staff as long as she had worked there. She stated it was not addressed in his service plan. She would just tell him to go to his room when he behaved like that. (Record review revealed Staff Q was hired 10/16/25). When interviewed on 5/6/26 at 5:55 a.m. Staff R reported all doors were to be locked and they needed to have someone in the hallway when Tenant #9 was present. Observations on 5/11/26 at 7:29 p.m. revealed Staff R communicated with Staff H to lock Tenant #9's door since no staff were in the hallway and she was laying in bed. At 7:34 a.m., Staff R left Tenant #2's room and locked the door. At 7:38 p.m., Staff R indicated she locked the doors because only one staff and with Tenant #9's sexual behaviors needed to lock the doors. Record review revealed Tenant #9's current service plan, dated 6/30/25, indicated occasional awareness issues and no disruptive or socially inappropriate behavior. Additional record review failed to produce evaluations following the change in Tenant #9's behavior requiring tenants' doors to be locked. When interviewed on 6/12/26 at 9:00am the Resident Services Coordinator (RSC) stated female staff reported he Tenant #9 would grunt and stare at them. The RSC recalled Staff M reported to both him and the HCC incidents regarding Tenant #9's sexual behaviors. Staff M reported Tenant #9 stated he wanted to have sex with her on the back patio. He reported staff made them aware a month to a month and a half prior. The HCC took no further action.	
481-69.23(1)c(1-2)	**481-69.23(231C) Criteria for admission and retention of tenants.** **69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who:** **c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who:**	

	(1) Despite intervention, chronically elopes or is sexually, verbally, or physically aggressive or abusive; or **(2) Displays behavior that places another tenant at risk; or** Based on observations, interview and record review the Program failed to ensure tenants residing within the Program did not exceed criteria for retention. The Program failed to timely address a tenant with verbal and physical sexual behaviors. Finding follows: Observations on 5/5/26 at 5:13 p.m. revealed Staff L and Staff O present in the memory care unit. At 5:17 p.m., Staff L indicated Tenant #9, a male tenant displayed sexual behaviors with comments to the staff. The Staff L indicated the Health Care Coordinator directed staff to lock the tenants bedroom doors. At 5:57 p.m., the HCC entered the unit and told staff the tenants' doors needed to be locked. She also told staff to do their checks and watch. At 6:05 p.m., Staff P walked down the hallway and locked each tenant's door. Record review revealed Tenant #9's incident report dated 5/5/26, indicated at 4:15 p.m. Tenant #9 asked staff for sexual behaviors. Continued record review revealed Tenant #9's Progress Notes included an entry by the HCC on 5/5/26. The notes indicated a call was made to the power of attorney (POA) following the tenant asking staff for sexual behaviors. An additional entry indicated a fax was sent to the primary care provider (PCP) about Tenant #9's behaviors. An entry on 5/6/26 noted a change of condition to the PCP regarding a change of behaviors.It further noted a message was left with the PCP. The new PCP was called and informed of his behaviors and she noted she would look at his medication and see what to change. No additional entries were made in regards to the 5/5/26 follow up. When interviewed on 5/5/26 at 6:35pm Staff Q reported Tenant #9 displayed inappropriate sexual behavior towards staff as long as she had worked there. She stated it was not addressed in his service plan. She would just tell him to go to his room when he behaved like that. (Record review revealed Staff Q was hired 10/16/25).	

	When interviewed on 5/6/26 at 5:55 a.m. Staff R reported all doors were to be locked and they needed to have someone in the hallway when Tenant #9 was present. Observations on 5/11/26 at 7:29 p.m. revealed Staff R communicated with Staff H to lock Tenant #9's door since no staff were in the hallway and she was laying in bed. At 7:34 a.m., Staff R left Tenant #2's room and locked the door. At 7:38 p.m., Staff R indicated she locked the doors because only one staff and with Tenant #9's sexual behaviors needed to lock the doors. Continued review of Progress notes indicated on 5/29/26 Staff M reported Tenant #9 was inappropriate with her and she did not want to be scheduled in the memory care unit. Tenant #9 talked sexually to staff and tenants on the memory care unit and made them uncomfortable. Additional entries indicated an internal investigation occurred. Tenant #9 made several concerning comments and behaviors that required a hospital admit. Tenant #9 returned from the emergency room with no changes. The Program implemented a one to one staff and staff documented every hour on Tenant #9. Continued review revealed Tenant #9's Incident Report dated 5/29/26, indicated an incident happened on 5/27/26, Staff M Staff M reported Tenant #9 was inappropriate with her and did not want to be scheduled in the memory care unit. Tenant #9 talked sexually to staff and tenants on the memory care and made them uncomfortable. Staff M informed the Resident Services Coordinator (RSC). Record review revealed a Program internal investigation regarding allegations of Tenant #9's inappropriate sexual behavior, dated 6/2/26. The investigation concluded Tenant #9 had increasing behaviors due to cognitive decline. Behaviors had become more sexual in nature, with Tenant #9 touching staff and making inappropriate comments, in addition to exposing himself multiple times. The investigation further noted a change of condition was completed and the service plan updated to include 1:1 care, redirection, and asking Tenant #9 to stop the behavior. Tenant #9's PCP and psychiatrist made medication changes. Further review of the Program's investigation revealed the following: a. An interview with Staff M noted Tenant #9 would groan towards female staff. Tenant #9 requested Staff M and others to "masturbate" him. Staff M reported she went to Tenant #9's	

	apartment in April to look for a shirt and he shoved her into the closet, trapping her against the wall and kissing her neck. As Staff M left his apartment she told him his behavior was inappropriate. Tenant #9 put his fingers into her backside and said, "I know we can't have sex inside, so we can go outside." Staff M further noted previous incidents of Tenant #9 trying to place his hand in her gential area. She also reported he would tell others the pregnancy Staff M carried was his and asked her when their next ultrasound was. Staff M reported she was uncomfortable working in the memory care unit. Tenant #9 would get an erection and walk behind Tenant #6. He would get close to another Tenant #11 and moan in her ear. The tenant would become upset and push him away. b. In an interview on 5/29/26 Staff B reported Tenant #9 tried to grab her bottom and breasts multiple times. Tenant #9 would constantly ask for sex and make growling noises. Staff B reported in mid-May Tenant #9 took his pants off in front of Tenant #6 and in front of her door, standing naked from the waist down. Staff redirected Tenant #9 and informed the Resident Services Coordinator (RSC), who directed them to make sure he kept his clothing on and increased checks. Tenant #9 had also been in Tenant #11's room, in her bed, shirtless. Tenant #11 was not in her unit, and unaware this occurred. Staff redirected him and removed him from the apartment. c. In an interview on 6/1/26 Staff C reported Tenant #9 would follow staff around and touch them. He tried to get Staff M outside to have sex with him.Staff C reported informing the RSC a few times, as well as the HCC. They advised to give a PRN (psych med). She reported the behavior became worse in May 2026. d. In an interview on 5/29/26 Staff X reported Tenant #9 once tried to touch her breasts while standing near her. She moved so he could not touch her. e. In an interview on 5/29/26 Staff L reported around 5/5/26 Tenant #9 asked "to be sexually manipulated (verbal)". She further reported Tenant #9 standing in Tenant #6's apartment, unzipping his pants. f. In an interview on 6/1/26 Staff H reported Tenant #9 would touch her hair, blow kisses toward her, and say he wanted to have sex with her. She would tell him to stop. She stated she would give report at shift change.	

	g. In an interview on 6/1/26 Staff Q reported Tenant #9 would make sexual comments toward her. He would say he wanted to sleep with her and ask for sexual favors. She stated she reported to Staff J. i. In an interview on 6/1/26 Staff Y reported Tenant #9 would stare at her a lot. When she reported it to the Regional Operations Specialist, she was told to redirect him. When interviewed on 6/12/26 at 9:00am the RSC stated female staff reported he Tenant #9 would grunt and stare at them. The RSC recalled Staff M reported to both him and the HCC incidents regarding Tenant #9's sexual behaviors. Staff M reported Tenant #9 stated he wanted to have sex with her on the back patio. He reported staff made them aware a month to a month and a half prior. The HCC took no further action. Record review revealed Tenant #9's Incident Report dated 5/30/26 indicated staff reported inappropriate behaviors by Tenant #9. He flicked the staff's hair and asked if he could lick her ear. Staff told Tenant #9 no and to stop. Tenant #9 then rubbed staff shoulders. He then indicated he would be superman and pick the staff up to carry her to his room. Staff told Tenant #9 no and to stop. Tenant #9 went to his room and closed his door. When interviewed on 6/03/26 at 11:42 a.m. the Regional Director of Operations and Regional Nurse Specialist indicated they decided they were not issuing a 30 day discharge for Tenant #9 for his sexual behavior due to this being the first time they heard about it. They reported Record review revealed the Program's huddle report dated 6/8/26 indicated Tenant #9 had two behaviors for the shift. The report further noted Tenant #9's name under "Behavior Concerns". Observations on 6/11/26 at 6:09 a.m. revealed Tenant #9 no longer provided 1:1 staff. Further observation at 6:14 a.m. revealed tenant doors were not locked. When interviewed on 6/22/26 at 5:54 p.m., Staff C report Tenant #9 left with his family on 6/20/26 and moved to a new facility. When interviewed on 6/23/26 at 1:21 p.m. the Health Care Coordinator confirmed Tenant #9 moved from the Program on	

	6/20/26. She reported the family had been unhappy with extra charges for 1:1 staffing to address Tenant #9's behavior. Record review failed to reveal a notice of involuntary discharge issued for Tenant #9.	
69.26(3)	**481-69.26(231C) Service plans.** **69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. The service plan shall be signed by all parties, including the tenant or tenant's legal representative.** Based on observations, interviews, and record review the Program failed to update tenant service plans following significant change in condition and failed to ensure all service plans were signed by applicable parties. Findings follow: 1. Observations on 5/5/26 at 5:13 p.m. revealed Staff L and Staff O present in the memory care unit. At 5:17 p.m., Staff L indicated Tenant #9, a male tenant displayed sexual behaviors with comments to the staff. The Staff L indicated the Health Care Coordinator directed staff to lock the tenants bedroom doors. At 5:57 p.m., the HCC entered the unit and told staff the tenants' doors needed to be locked. She also told staff to do their checks and watch. At 6:05 p.m., Staff P walked down the hallway and locked each tenant's door. Record review revealed Tenant #9's incident report dated 5/5/26, indicated at 4:15 p.m. Tenant #9 asked staff for sexual behaviors. Continued record review revealed Tenant #9's Progress Notes included an entry by the HCC on 5/5/26. The notes indicated a call was made to the power of attorney (POA) following the tenant asking staff for sexual behaviors. An additional entry indicated a fax was sent to the primary care provider (PCP) about Tenant #9's behaviors. An entry on 5/6/26 noted a change of condition to the primary care physician (PCP) regarding a change of behaviors.It further noted a message was left with the PCP. The new PCP was called and informed of his behaviors and she noted she would look	

	at his medication and see what to change. No additional entries were made in regards to the 5/5/26 follow up. When interviewed on 5/5/26 at 6:35pm Staff Q reported Tenant #9 displayed inappropriate sexual behavior towards staff as long as she had worked there. She stated it was not addressed in his service plan. She would just tell him to go to his room when he behaved like that. (Record review revealed Staff Q was hired 10/16/25). When interviewed on 5/6/26 at 5:55 a.m. Staff R reported all doors were to be locked and they needed to have someone in the hallway when Tenant #9 was present. Observations on 5/11/26 at 7:29 p.m. revealed Staff R communicated with Staff H to lock Tenant #9's door since no staff were in the hallway and she was laying in bed. At 7:34 a.m., Staff R left Tenant #2's room and locked the door. At 7:38 p.m., Staff R indicated she locked the doors because only one staff and with Tenant #9's sexual behaviors needed to lock the doors. Record review revealed Tenant #9's current service plan, dated 6/30/25, indicated occasional awareness issues and no disruptive or socially inappropriate behavior. Additional record review failed to produce evaluations following the change in Tenant #9's behavior requiring tenants' doors to be locked. When interviewed on 6/12/26 at 9:00am the Resident Services Coordinator (RSC) stated female staff reported he Tenant #9 would grunt and stare at them. The RSC recalled Staff M reported to both him and the HCC incidents regarding Tenant #9's sexual behaviors. Staff M reported Tenant #9 stated he wanted to have sex with her on the back patio. He reported staff made them aware a month to a month and a half prior. The HCC took no further action.	