DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0065	A. BUILDING: _____ B. WING _____	C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PLACE	1140 K AVENUE NW CEDAR RAPIDS, IA 52405

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A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 9 Tenants with cognitive impairment: 14 Total census: 23 Complaint #130363-C was investigated and no regulatory insufficiencies were cited. The following regulatory insufficiencies were cited related to the investigation of Incident #131098-I and the recertification visit conducted to determine compliance with certification a Dedicated Dementia Specific Assisted Living Program:	A 000	See attached POC 2/5/26	
A 361	481-67.9(4)f 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, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on interview and record review the Program failed to ensure staff consistently provided services consistent with dementia training provided. This pertained to 1 of 1 staff reviewed related to dementia training (Staff A)	A 361		

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A 361	Continued From page 1 and an incident involving Tenant #3. Finding follow: Record review of an internal investigation indicated on 12/23/25 Staff A left a voicemail for the Director of Health Services at 1:31 p.m. In the voicemail Staff A sounded frantic and upset. Staff A said different locks were needed on the refrigerators, Tenant #3 was going in and out of the refrigerators and Staff A removed juice and soda from Tenant #3. In the voicemail, Staff A indicated she took the items from Tenant #3, then Tenant #3 hit Staff A and pulled her hair. Staff A indicated Tenant #3 was becoming more violent. The Director of Health Services noted concern as "the actions described did not align with dementia care training or established behavioral intervention protocols." It also noted Staff A recently attended an in-person dementia education on 12/17/25 and completed dementia training throughout the year. The investigation document revealed Staff A was removed from the schedule and asked to write up a statement. Staff A indicated she already wrote a statement and placed it in the Nurse Manager's mailbox. Tenant #3 was interviewed on 12/23/25 and had no recollection of the incident. Tenant #3 said staff were kind to her and she had no concerns with her safety. Tenant #3 was assessed and there were no injuries or marks noted. Staff in the building were re-educated on proper approach. On 12/29/25 at 1:15 p.m. Staff A was contacted by phone and informed she was terminated immediately. She asked why the decision was made and was told she had ongoing training and coaching related to dementia care and approaches. In the past several months she had "failed to consistently apply those approaches in practice."	A 361		

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A 361	Continued From page 2 Staff A and Staff B were both no longer employed by the Program and unable to provide an interview. Record review of staff statements indicated the following: a. Staff A provided two written statements. Staff A ' s first statement, dated 12/23/25 indicated Tenant #3 became more and more violent. On 12/22/25 a staff took items from her and Tenant #3 kicked her. On 12/23/25 Staff A took soda from her and Staff A's cup, she hit Staff A and pulled her hair. It was noted she kept going into the refrigerator. b. Staff A ' s second statement dated 12/24/25 indicated on 12/23/25 at breakfast Staff A took a bottle of soda from a tenant, Tenant #3 went into the refrigerator and got. Tenant #3 told Staff A to "go to hell my reply to her was to get the address." Later in the day Staff A started a movie for tenants. Someone came into the building and needed information regarding another tenant. Staff A went over, talked to her and forgot she left her cup on the table. When Staff A returned, Tenant #3 drank out of her cup. Staff A told Tenant #3 to give her the cup and she took it from her. Tenant #3 started screaming, she hated Staff A and she was going to get her. Tenant #3 hit Staff A and grabbed her hair. She put a note in the Nurse Manager's mailbox and notified the Director of Health Services. c. Staff B ' s statement indicated Staff A and Tenant #3 got into a physical altercation because Tenant #3 passed around a liter of pop and shared it with another tenant. Tenant #3 stayed seated, did not do anything but was saying "stuff." A few minutes later, Tenant #3 walked over to the table by the television and took Staff	A 361		

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A's water bottle. Staff B did not know it was Staff A's water bottle. Staff A saw her drinking out of it, went over to Tenant #3 and took it out of Tenant #3's hands. She did not remember a lot of details as there was a lot said and done. She remembered Staff A getting angry and Tenant #3 too. Staff A tried to take the water bottle out of Tenant #3's hands, Tenant #3 refused and started playing "tug of war with it." Staff A finally grabbed it and Tenant #3 hit Staff A on the shoulder and Staff A hit Tenant #3 back on the shoulder. Staff A walked away and Tenant #3 said she was going to get her. Tenant #3 went up behind Staff A and pulled on her hair and they were playing "tug of war with her hair." Staff A got away and it ended. Tenant #3 cried and Staff A wrote her up.

When interviewed on 1/07/26 at 1:31 p.m. Staff C reported she did not see anything and only heard. She indicated Tenant #3 took whatever she wanted out of the refrigerator. Tenant #3 was seated at the table with Staff A's water. She picked up Staff A's water and drank it. Staff A went off, yelled, said you don't take other people's stuff and what are you doing. Staff C's back was against as she was completing her stock orders. Staff C was in the same room as Staff A and Tenant #3; she was at the housekeeping closet. Staff C stood up and turned around and Tenant #3 said something like you did mine first (she thought it was pulling hair). Staff C did not see Tenant #3 pull Staff A's hair and did not see anything occur between Staff A and Tenant #3. Staff A grabbed her cup and said she was going to sterilize it. Staff C reported Staff A was very upset and went overboard on her actions. Staff C thought Staff A should have been cool and cleaned her water bottle. Nothing physical was observed between either Staff A or

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Tenant #3 otherwise Staff C would have intervened. She said Tenant #3 would tell staff to go to hell if they stopped her from going into the refrigerator. Staff could not control her. Staff C thought Staff A was overwhelmed with Tenant #3's actions.

Continued record review revealed Staff A had the eight hours of dementia training indicated on a training transcript most recently completed in January of 2025. The training included courses on understanding dementia, communication, behavior management and abuse prevention, philosophy of care, family and staff issues, ethical issues, activities of daily living, medication and nutrition and activities for persons with dementia. Per timecard records, she was also in the building when an in-person dementia training was held on 12/17/25. Staff A had the required dementia training; however, related to the incident with Tenant #3, she failed to provide services in accordance with dementia training as described above in staff statements and interviews.

When interviewed on 1/07/26 at 10:49 a.m. the Director of Health Services indicated Staff A left a voicemail message for her and it was the opposite of training she completed. There was excitement in the voicemail. She reported Tenant #3 got a bottle of soda and Staff A took it away from her and Tenant #3 got aggressive with Staff A and something needed to be done about the lock on the refrigerator. The Director of Health Services reached out to staff. She spoke with Staff B who reported Staff A took the bottle of soda, Tenant #3 picked up Staff A's water bottle, it aggravated Staff A. Staff A said to give her the water bottle in an aggressive/agitated tone and

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A 361	Continued From page 5 abruptly took the water bottle. Staff B said Tenant #3 hit Staff A on the arm and Staff A hit Tenant #3 on the arm. Staff B indicated it was not forceful, it was shocking to her. Staff B said there was anger from both of them. The Director of Health Services spoke with Staff A, she was very short with the director and she denied hitting Tenant #3 but did not deny her angry tone. Staff A indicated she would never harm a tenant. The director said Tenant #3 was interviewed at 3:00 p.m. (day of incident) and had no recollection of the incident. Tenant #3 was assessed,no injuries noted and felt safe. There were no cameras that captured the incident. She said Staff A could verbalize the right steps and provided the right answers (related to dementia training) but was not able to apply in the situation. She had dementia training completed. She said Tenant #3 did not like to be told no and did like things to be taken away from her. She enjoyed meaningful activities and liked to feel needed. Tenant #3 had a short fuse and wanted to be engaged. When interviewed on 1/08/26 at about 2:15 p.m. the Director of Health Services, Nurse Manager and Social Worker reported Staff A gave answers related to her dementia training. In her August training she verbalized it but was not applying it. She gave such good answers and knew how to present it. They said she presented to them like training was working.	A 361		
A 365	481-67.9(4)g 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, at a minimum, include the following:	A 365		

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A 365	Continued From page 6 g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to have non-certified and certified staff document in writing occurrences that differed from the tenant's normal health, functional and cognitive status. This pertained to 1 of 4 current tenants reviewed (Tenant #3). Finding follows: Record review on 1/06/26 of Tenant #3's file revealed the service plan indicated Tenant #3 had periods of tearfulness, which were short lived. She was possessive of the piano bench and could be aggressive and try to push others off of the bench. Staff were to intervene. When interviewed on 1/07/26 at 1:31 p.m. Staff C reported Tenant #3 swore at tenants and staff. She made verbal comments to tenants and some	A 365		

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A 365	Continued From page 7	A 365		

tenants cried. It was daily occurrences with Tenant #3. She took another tenant's walker, she did not want the other tenant anywhere near the piano. She told the other tenant she was going to kill her. She also made verbal comments to staff if they stopped her from going into the refrigerator. Some tenants kept their door locked due to Tenant #3 wandering in.

When interviewed on 1/05/26 at 1:35 p.m. Staff D indicated one tenant could be aggressive and she identified Tenant #3. She explained Tenant #3 was physically aggressive, mainly towards staff. She hit a staff in the back while they were giving her a shower.

When interviewed on 1/05/26 at 2:12 p.m. Staff E reported Tenant #3 had verbal behaviors towards staff or tenants. She recalled when one tenant rubbed her walker and Tenant #3 got agitated. One time Tenant #3 took and put the other tenant's walker in the room. She redirected Tenant #3 by offering her a soda.

When interviewed on 1/05/26 at 3:10 p.m. Staff F indicated Tenant #3 had behaviors, occasionally, but not all of the time. Tenant #3 was both physical and verbal but usually verbal. She kicked other tenants and no one was harmed.

Continued record review revealed a Resident Behavior Log noted on 1/03/26 at 12:30 p.m. Tenant #3 slammed a chair into another tenant's legs and yelled that she did not like her. It noted the other tenant asked her to play the piano. At 12:47 p.m., Tenant #3 took ranch and juice out of the refrigerator. She told staff she did not like her and used profanity. It noted she was difficult to redirect and told staff to shut up.

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A 365	Continued From page 8 Further record review revealed there were no additional staff to nurse sheets or documentation related to behaviors as noted above in staff interviews. When interviewed on 1/08/26 at 12:16 p.m. the Nurse Manager and Social Worker confirmed all staff to nurse notes were provided for Tenant #3. Staff reported verbally and would write on a sticky note and put it in the Nurse Manager's mailbox. For Tenant #3, there were now smaller bottles of soda and staff were to reapproach with aggressive behaviors. Staff intervened as needed.	A 365		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed and develop service plans to reflect the identified needs of the tenants. This pertained to 4 of 4 current tenants reviewed (Tenants #1, #2, #3 and #4) and 2 of 2 discharged tenants	A 350		

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reviewed (Tenant C1 and Tenant C2). Findings follow

1. Record review on 1/06/26 of Tenant #1's file revealed the service plan reflected for toileting needs, Tenant #1 wore briefs, was incontinent of urine and more frequently bowel. Staff assisted as needed.

When interviewed on 1/08/26 at 12:16 p.m. the Nurse Manager and Social Worker reported staff anticipated Tenant #1 ' s needs and it was before and after meals. She did things on her own regarding toileting needs. Staff escorted her to the apartment, made her aware but did not provide physical assistance.

Continued record review revealed Tenant #1's service plan failed to reflect the type of assistance Tenant #1 required from staff for her toileting needs, as indicated from the interview above.

2. Record review on 1/06/26 of Tenant #2's file revealed an Interdisciplinary Note, dated 12/18/25, indicated Tenant #2 required convincing for showers due to being scared of water. Staff assisted with her shower as needed.

Tenant #2's service plan reflected she required the assistance of one person with bathing, staff washed her hair and folds. The service plan did not reflect Tenant #2 required convincing (related to bathing) or she was scared of water.

3. Record review on 1/06/26 of Tenant #3's file revealed the service plan indicated Tenant #3 had periods of tearfulness, which were short lived. She was possessive of the piano bench

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A 350	Continued From page 10 and could be aggressive and try to push others off of the bench. Staff were to intervene. When interviewed on 1/07/26 at 1:31 p.m. Staff C reported Tenant #3 swore at tenants and staff. and took another tenant's walker. She had made verbal comments to tenants and some tenants cried. It was daily occurrences with Tenant #3. She took another tenant's walker, she did not want the other tenant anywhere near the piano. She had told the other tenant she was going to kill her. She also made verbal comments to staff if they stopped her from going into the refrigerator. Some tenants kept their door locked due to Tenant #3 wandering in. When interviewed on 1/05/26 at 1:35 p.m. Staff D indicated one tenant could be aggressive and she identified Tenant #3. She explained Tenant #3 was physically aggressive, mainly towards staff. She hit a staff in the back while they were giving her a shower. When interviewed on 1/05/26 at 2:12 p.m. Staff E reported Tenant #3 had verbal behaviors towards staff or tenants. She recalled when one tenant rubbed her walker and Tenant #3 got agitated. One time Tenant #3 took and put the other tenant's walker in the room. She redirected Tenant #3 by offering her a soda. When interviewed on 1/05/26 at 3:10 p.m. Staff F indicated Tenant #3 had behaviors, occasionally, but not all of the time. Tenant #3 was both physical and verbal but usually verbal. She	A 350		

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A 350	Continued From page 11 kicked other tenants and no one was harmed. Continued record review revealed a Behavior Log noted on 1/03/26 at 12:30 p.m. Tenant #3 slammed a chair into another tenant's legs and yelled that she did not like her. It was noted the other tenant asked her to play the piano. At 12:47 p.m., Tenant #3 took ranch and juice out of the refrigerator. She told staff she did not like her and used profanity. It noted she was difficult to redirect and told staff to shut up. Tenant #3's service plan failed to reflect the extent of Tenant #3 behaviors and interventions related to those behaviors. 4. Record review on 1/06/26 of Tenant #4's file revealed Interdisciplinary Notes indicated the following: a. 10/29/25, speech therapy (ST) started on 9/11/25 and would be discontinued on 10/31/25. b. 11/17/25, an order was sent to the Primary Care Physician (PCP) for physical therapy (PT) for strengthening and balance. c. 12/12/25, Tenant #4 had a fall. Continued record review revealed the following: a. A fax to the PCP, dated 11/14/25 requested an order for PT to evaluate and treat for strengthening and balance. A signed order was received dated 11/24/25. b. A fax to the PCP,dated 12/12/25 indicated Tenant #4 fell and sustained a small abrasion on the bridge of his nose and rug burn to the right	A 350		

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A 350	Continued From page 12 knee. An order was requested for as needed Tylenol for pain. An order was received for Tylenol 500 milligram (mg), take one to two tablets by mouth every six hours as needed for pain. Further record review revealed incident reports noted the following: a. 8/30/25, Tenant #4 slipped off the bed. b. 10/10/25, Tenant #4 reported he fell and no one witnessed it. He was not able to indicate why or how he fell. c. 12/12/25, Tenant #4 fell and sustained an abrasion. Tenant #4's service plan failed to reflect the therapies or the history of falls. 5. Record review on 1/06/26 of Tenant C1's file revealed an Interdisciplinary Note dated 7/24/25 indicated orders were received for a urinalysis (UA) related to increased confusion and an order for PT related to increased difficulty with ambulation. An email from the Nurse Manager dated 1/8/26 indicated the dates of PT for Tenant C1 were from 7/29/25 to 9/04/25. Tenant C1's service plan failed to reflect PT services. 6. Record review on 1/06/26 of Tenant C2's file revealed Interdisciplinary Notes indicated the following:	A 350		

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A 350	Continued From page 13 a. 8/13/25 , due to falls, new orders were received including for a UA. b. 8/18/25, lab results were sent to the PCP and a new order was received for Augmentin 875-125 mg, twice daily for seven days. c. 8/18/25, Tenant C2's family was informed Tenant C2 had a urinary tract infection (UTI) and would be starting an antibiotic. d. 8/29/25, Tenant C2 returned to baseline after the UTI. e. 9/14/25, Tenant C2 was found on the floor and his family requested a UA due to recent falls. The PCP was notified and an order was received for a UA with culture and sensitivity. f. 9/16/25, there were several attempts to collect the urine sample. Tenant C2 was showing no signs of a UTI. A new order was received from the PCP to discontinue the order for UA with culture and sensitivity. g. 9/28/25, he was found on the floor in the hallway. He was assisted up and family requested he be transported to the emergency department (ED). h. 9/28/25, Tenant C2 was discharged from the ED with a UTI. He was given one dose of Keflex in the ED. i. On 9/29/25, Tenant C2 had a new order for cephalexin 500 mg, one capsule four times per day for five days. Tenant C2's service plan failed to reflect Tenant	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0065	A. BUILDING: _____ B. WING _____	C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR PLACE	1140 K AVENUE NW CEDAR RAPIDS, IA 52405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 14 C2 had a history of UTIs and treatment. When interviewed on 1/08/26 at 12:16 p.m. the Nurse Manager and Social Worker confirmed for Tenant C1, PT was not on the service plan and for Tenant C2, the history of UTIs was not on the service plan. For Tenant #2, the fear of water was not reflected in her service plan. Regarding Tenant #4 the PT and falls were not on the service plan. For Tenant #3, there were now smaller bottles of soda and staff were to reapproach with aggressive behaviors. Staff intervened as needed. There was no harm to anyone. All current service plans were provided for the tenants reviewed.	A 350		

Arbor Place Assisted Living
1140 K Avenue NW,
Cedar Rapids, IA 52405
Recertification, Investigations # 130363-C, 131098-I

March 13, 2026

A 361 Staffing

1. Please accept this as Arbor Place Assisted Living credible allegation of compliance.

2. Staff (A) was immediately removed from the schedule following the incident that occurred on December 23, 2025. The facility promptly conducted an internal investigation to review the circumstances surrounding the event. Upon completion of the investigation, Staff (A) was terminated.

3. Staff received retraining on required competencies related to supporting tenants living with dementia, including appropriate care approaches and communication techniques.

4. In addition, the facility has implemented a plan to provide in-person training on proper dementia care approaches quarterly to ensure staff maintain the knowledge and skills necessary to meet the individual needs of tenants.

A 365 Staffing

1. Please accept this as Arbor Place Assisted Living credible allegation of compliance.

2. The program has implemented a formal system for written communication of any occurrences that differ from a resident's normal health, functional or cognitive status. All staff will document such changes promptly in the designated communication log and notify the RN or designee for follow-up.

3. The RN or designee will provide education to all staff on recognizing changes in resident status, proper reporting procedures and documentation. This training was completed for all current staff on 2/5/2026 and is incorporated into orientation for all new employees.

A 365 Staffing

1. Please accept this as Arbor Place Assisted Living credible allegation of compliance.

2. On 1/8/2026 Tenants 1, 2, 3, and 4's service plans were reviewed and updated with current needs.

3. Service Plans will be audited with 90-day reviews to ensure the service plan is individualized and includes the tenants' needs and preferences for assistance.

4. On 1/8/2026 staff were retrained on service plans and what should be included to ensure service plans are individualized and ensure tenants' needs and preferences are met.