

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/05/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LAWTON SENIOR LIVING

**200 E CHAR-MAC DR
LAWTON, IA 51030**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time the on-site visit was initiated (4/9/26): Tenants without cognitive impairment: 17 Tenants with cognitive impairment: 10 Total census: 27 Investigations 131512-C, 131673-C, 131861-C, 131862-C, 131865-I, 131875-C, 131876-I, 131903-C, 132144-I, and 132174-C were conducted and Lawton Senior Living. Based on observations, interviews, and record reviews, the management company failed to provide adequate oversight and operational direction to maintain a safe, healthy environment and ensure consistent service delivery to tenants at Lawton Senior Living. The program demonstrated systemic breakdowns, including failure to respond in an appropriate or timely manner to significant tenant medical and behavioral events. Furthermore, management failed to ensure the proper oversight and handling of controlled substances, leading to unauthorized medication destruction, unprescribed drug dosing, and medication administration by unqualified or uncertified staff. Additionally, chronic staffing shortages left the memory care unit understaffed, resulting in improper behavioral interventions, violations of tenant rights, lack of provision of care, unsanitary living conditions due to unmanaged incontinence, uncompleted background checks, lack of nurse delegations,	A 000		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 000	Continued From page 1 and involuntary discharge protocols failed to comply with state requirements. Findings follow:	A 000			
A 116	481-67.2(2) Program Policies and Procedures 67.2(2) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to consistently implement established policies and procedures regarding tenant health and safety. This affected 3 of 10 sample tenants (Tenant #1, Tenant #5, and Tenant #8) and 1 of 2 discharged tenants (Tenant #C1). Findings follow: 1. 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.	A 116			

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A 116	Continued From page 2 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 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.	A 116		

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A 116	Continued From page 3 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.	A 116		

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A 116	Continued From page 4 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	A 116			

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A 116	Continued From page 5 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. b. Record review on 06/03/26 revealed an	A 116		

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A 116	Continued From page 6 incident report dated 03/21/26, indicating Staff A called the program's triage nursing personnel to report Tenant #8 had a choking episode during which Staff A performed the Heimlich maneuver three times. When requested on 06/04/26 at 7:40 a.m. to provide a factual written statement from Staff A regarding the choking incident, the Regional Director of Operations replied via email on 06/09/26 at 8:26 a.m. stating Staff A's statement could not be located. c. Review on 05/04/26 identified the program self-reported an incident on 03/25/26 regarding the discovery of a 28-count bubble pack card of Alprazolam belonging to Tenant #1 was missing. Record review on 05/11/26 revealed a written statement dated 03/25/26 from the former Executive Director (ED) and Health Care Coordinator (HCC). The statement noted the program believed a total of 34 Alprazolam tablets belonging to Tenant #1 were unaccounted for, though it lacked details explaining how the additional six missing tablets were calculated. Continued record review on 05/21/26 of a law enforcement report dated 03/25/26 revealed the program contacted local law enforcement regarding the suspected theft of Tenant #1's 34 missing Alprazolam tablets. During an interview on 05/11/26 at 4:00 p.m., the HCC stated she had not completed an incident report regarding Tenant #1's missing Alprazolam during the initial investigation, explaining it was her first day in the building and she was unfamiliar with the process. (Record review verified the HCC's hire date was 03/04/26.)	A 116		

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A 116	Continued From page 7 d. Continued record review on 05/21/26 of the law enforcement report revealed the program contacted local law enforcement again two days later, on 03/27/26, to report the suspected theft of an additional 60 tablets of Lorazepam belonging to Tenant #5. During an interview on 05/26/26 at 1:55 p.m., the HCC acknowledged she failed to complete an incident report when the 60 missing Lorazepam tablets were first discovered on 03/27/26. 3. Record review on 05/26/26 of the program's Missing Controlled Substances policy (dated 10/15/25) revealed mandatory investigation standards, including: Any missing, lost, or misused controlled substance must be reported immediately, investigated thoroughly, and documented according to regulatory standards. Investigative interviews must be conducted with the resident (if applicable) and all staff members who had access to medications on the shift in question, as well as staff from a minimum of one shift prior and one shift after (unless circumstances warrant expanding the scope to additional shifts). a. Record review on 05/04/26 revealed the program self-reported an incident on 03/25/26 concerning a narcotic count discrepancy for Tenant #1's Alprazolam. The program noted Tenant #1's Alprazolam bubble pack card had 16 tablets remaining, but the narcotic count sheet indicated 17 tablets should have been present. The program reviewed the Electronic Medication Administration Record (eMAR), which showed no	A 116		

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A 116	Continued From page 8 as-needed (PRN) doses had been administered in the preceding 60 days. The program called the pharmacy, which confirmed a delivery on 02/11/26, and an additional 28-dose card delivered on 03/11/26. Upon receiving this information, the program discovered the 28-dose card delivered on 03/11/26 was missing entirely. An Internal Investigation form dated 03/25/26 at 3:30 p.m. confirmed these details. The form directed staff to include all reviewed documents in the investigative file (noting eMARs, count sheets, and pharmacy manifests were checked). The form listed only Tenant #1 and Staff A as interviewed parties and was left unsigned and undated by the Executive Director or Nurse. Record review on 05/11/26 revealed a statement dated 03/25/26 (timestamped 18:42) from the former ED and HCC revealed they believed 34 total tablets were unaccounted for, without documenting how that total was derived. A law enforcement report dated 03/25/26 confirmed local police were contacted regarding 34 missing Alprazolam tablets. During an interview on 05/11/26 at 4:00 p.m., the HCC stated the missing count was 34 tablets (consisting of a 30-count card plus 4 additional tablets). While attempting to pull up narcotic counts on her computer, the HCC mistakenly reviewed the narcotic sheets for Tenant #5 instead of Tenant #1. She asserted staff made subtraction errors on the sheets, pointing to entries marked "error." Upon realizing she was viewing the wrong tenant's file, the HCC conjectured some of the 34 missing tablets might have been Tenant #5's Lorazepam. When asked to provide the narcotic count sheet	A 116		

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A 116	Continued From page 9 showing the original discrepancy (16 vs. 17 tablets) for Tenant #1 on 03/25/26, the HCC printed all of Tenant #1's count sheets and acknowledged they were "a mess" because staff routinely handwrote new sheets without clarifying whether they applied to scheduled bedtime doses or PRN doses. The HCC could not produce documentation verifying the reported discrepancy. She acknowledged multiple staff members had access to the narcotics, but confirmed she only verbally interviewed the staff members on duty at the time of discovery. She stated it was her first day in the building and she was unfamiliar with the process. Based on the lack of supporting documentation, failure to locate the original discrepancy sheet, and the HCC's statements, the program failed to thoroughly investigate the incident, failed to interview all staff with access to the medication, and failed to interview staff from at least one shift prior and one shift after, contrary to its Missing Controlled Substances policy. b. Record review on 05/21/26 of a law enforcement report dated 03/25/26 showed the program contacted police again on 03/27/26 to report an additional 60 missing Lorazepam tablets belonging to Tenant #5. An Internal Investigation form dated 03/27/26 noted the program attempted to reorder Tenant #5's morning dose and discovered two bubble pack cards (morning and bedtime doses delivered 03/17/26) were missing. The form noted Tenant #5 had not missed any doses. However, the "Documents Reviewed," "Persons Interviewed," and "Summary of Investigative Findings" sections were left blank. The conclusion section speculated the medication	A 116		

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A 116	Continued From page 10 went missing at the same time as Tenant #1's Alprazolam on 03/25/26. The form was unsigned and undated by facility leadership. During an interview on 05/26/26 at 1:55 p.m., the HCC located an electronic record showing 60 Lorazepam tablets were logged as destroyed on 03/20/26 by herself and Staff D. The HCC admitted she conducted no staff interviews regarding Tenant #5's missing Lorazepam. During a follow-up interview at 4:20 p.m., the HCC explained the medications were initially thought to be missing, but she had actually destroyed them with Staff D on 03/20/26. When asked why she reported them stolen to the police on 03/27/26, the HCC stated she forgot she had destroyed them, noting 03/20/26 was her first time performing medication destruction while shadowing Staff D. During an interview on 06/02/26 at 10:45 a.m., Staff D stated she was only on-call about once a week and had worked with the HCC for only a day or two. Staff D stated she never performed medication destruction at the facility. When presented with the 03/20/26 destruction log bearing her signature, Staff D denied writing the signature (noting the letter "N" was not formatted in her handwriting) and reiterated she never popped out or destroyed medications. Staff D recalled discussing Tenant #1's missing Alprazolam with the HCC on 03/20/26, but denied destroying any drugs. Staff D stated the HCC called her the following week to inform her Tenant #5's two bubble packs were missing. On 06/09/26 at 12:33 p.m., the Resident Services Coordinator (RSC) stated destroying Tenant #5's Lorazepam made no sense because the tenant took the medication daily (morning, night, and	A 116			

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A 116	Continued From page 11 PRN), meaning newly delivered stock would not be expired or eligible for destruction. Based on documentation reviews and conflicting staff statements, the program failed to thoroughly investigate the loss of Tenant #5's medication, failed to interview staff with access to the medication, and failed to interview staff from surrounding shifts as required by policy. 4. Continued record review of the program's Missing Controlled Substances policy verified controlled substances must be stored in a double-locked, secure location at all times. Additionally, the program's Medication and Medication Administration policy (dated 07/01/25) specifies any wasted or destroyed medication must be witnessed and documented by two staff members. Observations conducted on 05/20/26 between 4:48 p.m. and 5:04 p.m. revealed medication cassettes sitting unsecured on the Resident Services Coordinator's (RSC) desk. The HCC stated the RSC was destroying the medications. The RSC stated there was a month's worth of tenant medications sitting in the office. While the HCC cleaned the office, the RSC independently counted and destroyed the medications. The RSC reviewed the bubble packs, recorded the medication names and quantities destroyed, popped the tablets into a destruction bottle, and then initialed and signed the destruction logs alone. When interviewed on 05/20/26 at 4:48 p.m., the HCC incorrectly stated medication destruction required only one staff signature.	A 116		

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A 121	Continued From page 12	A 121		
A 121	481-67.3(1) Tenant Rights 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. This REQUIREMENT is not met as evidenced by: 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	A 121		

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NAME OF PROVIDER OR SUPPLIER LAWTON SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 200 E CHAR-MAC DR LAWTON, IA 51030		
(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 121	Continued From page 13 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. 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.	A 121		
A 122	481-67.3(2) Tenant Rights 481-67.3(231B,231C,231D) Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services that are adequate and appropriate.	A 122		

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A 122	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide adequate and appropriate care, treatment, and services for 2 of 2 discharged tenants reviewed (Tenant #C1 and Tenant #C2). Findings follow: 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 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	A 122		

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A 122	Continued From page 15 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	A 122			

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A 122	Continued From page 16 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)	A 122			

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A 122	Continued From page 17 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	A 122			

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A 122	Continued From page 18 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	A 122			

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STREET ADDRESS, CITY, STATE, ZIP CODE

LAWTON SENIOR LIVING

**200 E CHAR-MAC DR
LAWTON, IA 51030**

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A 122	Continued From page 19 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	A 122		

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A 122	Continued From page 20 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	A 122			

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A 122	Continued From page 21 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	A 122		

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A 122	Continued From page 22 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	A 122		

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A 122	Continued From page 23 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. 2. Record review on 5/11/26 revealed Tenant #C2 admitted to the program on 11/24/25. Record review on 5/19/26 of the March 2026 Medication Administration Record (MAR) for Tenant #C2 revealed two Lorazepam orders: *Lorazepam 0.5mg, take 1 tablet by mouth every 6-8 hours as needed for anxiety with an order start date of 3/3/26 *Ativan (Lorazepam) 0.5mg tablet, take 0.25mg by mouth three times per day every day at 10:00a.m., 1:00p.m., and 4:00p.m. The MAR revealed the following doses had been administered: On 3/6/26: *PRN doses administered at 12:15a.m., 6:17a.m., and 11:36p.m. *Doses administered at scheduled times of 10:00a.m., 1:00p.m., and 4:00p.m. On 3/7/26: *PRN dose administered at 5:40a.m. *Doses administered at scheduled times of 10:00a.m., 1:00p.m., and 4:00p.m. On 3/8/26: *No PRN doses administered	A 122		

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NAME OF PROVIDER OR SUPPLIER

LAWTON SENIOR LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE

**200 E CHAR-MAC DR
LAWTON, IA 51030**

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A 122	Continued From page 24 *Doses administered at scheduled times of 10:00a.m., 1:00p.m., and 4:00p.m. On 3/9/26: *PRN doses administered at 6:30am and 11:32p.m. *Doses administered at scheduled times of 10:00a.m., 1:00p.m., and 4:00p.m. On 3/10/26: *PRN doses administered at 5:45a.m. and 11:13p.m. *Doses administered at scheduled times of 10:00a.m., 1:00p.m., and 4:00p.m. On 3/11/26: *PRN dose administered at 5:39a.m. *Doses administered at scheduled times of 10:00a.m., 1:00p.m., and 4:00p.m. On 3/12/26: *Both the PRN and scheduled entries noted LOA for Leave of Absence On 3/13/26: *The PRN entry was noted LOA for Leave of Absence *Dose administered at scheduled time of 4:00p.m. On 3/14/26: *PRN dose administered at 11:34p.m. *The scheduled dose entries were noted LOA for Leave of Absence On 3/15/26: *PRN dose administered at 7:50p.m. *Doses administered at scheduled times of 10:00a.m., 1:00p.m., and 4:00p.m.	A 122		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/05/2026
NAME OF PROVIDER OR SUPPLIER LAWTON SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 200 E CHAR-MAC DR LAWTON, IA 51030		
(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 122	Continued From page 25 On 3/16/26: *PRN dose administered at 2:15a.m. * Doses administered at scheduled times of 10:00a.m., 1:00p.m., and 4:00p.m. On 3/17/26: *No prn doses administered *Doses administered at scheduled times of 10:00a.m., 1:00p.m., and 4:00p.m. On 3/18/26: *PRN doses administered at 12:05am and 11:57p.m. *Doses administered at scheduled times of 10:00a.m., 1:00p.m., and 4:00p.m. On 3/19/26: *PRN dose administered at 11:28p.m. *Doses administered at scheduled times of 10:00a.m., 1:00p.m., and 4:00p.m. The scheduled Ativan 0.25mg by mouth three times per day was then noted as discontinued on the MAR as of 3/21/26. Physician orders prescribed 3/2/26 confirmed the PRN dose every 6-8 hours, but the Regional Nurse Specialist confirmed via email on 5/29/26 no Ativan 0.25mg order was on file at the program. Review of a narcotic count sheet labeled as Lorazepam 0.5mg, 1 tab every 6-8 hours as needed for Tenant #C2 noted an entry dated 3/8/26 at 11:30am signed out as administered by Staff E and noted amount given as ½, with the total count going from 18 tablets to 17 ½ tablets, with notation of per Staff D. This entry was the only entry which noted a ½ tablet (0.25mg) had been administered of all Tenant #C2's narcotic	A 122			

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A 122	Continued From page 26 count sheets reviewed for March. None of the narcotic count sheets were labeled as a 0.25mg scheduled dose. When interviewed on 6/3/26 at 3:37p.m. Staff C stated she could not recall if Tenant #C2 had Ativan medication bubble packs with ½ tablets (0.25mg), but confirmed if there had been, the cards would have had a pharmacy label printed on the top of the card. When interviewed on 6/4/26 at 12:07p.m. Staff B recalled several days when she would have administered Tenant #C2's Lorazepam and remembered there was more than one bubble pack, but believed at one point the scheduled card ran out and staff began using from the prn card (0.5mg). Staff B could not recall any split pills and believed it was always a full tablet administered. On 6/1/26 the Pharmacy Manager of Tenant #C2's providing pharmacy indicated via email communication at 1:15p.m. the pharmacy never received an order for Tenant #C2's scheduled 0.25mg Ativan (Lorazepam). The Pharmacy Manager further confirmed at 2:14p.m. via email communication if the pharmacy had received an order for 0.25mg Ativan (Lorazepam), the pharmacy would have used a 0.5mg tablet and pre-split the tablet and packaged a ½ tablet (0.25mg) into each bubble of the dosing card. On 6/15/26 Tenant #C2's primary care provider (PCP) provided a letter response confirming she prescribed the following orders: *3.2.26 approving a faxed request from Staff D for Lorazepam 0.5mg every 4 hours. *3.2.26 Lorazepam 0.5mg every 6-8 hours as	A 122			

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A 122	Continued From page 27 needed. (The PCP confirmed this order was not in addition to the previous Lorazepam order approved earlier in the day.) *3.5.26 Lorazepam 0.5mg, changing the order from PRN to TID (3x daily) every 8 hours. (The PCP confirmed this order did not state specific times, just should be 8 hours apart.) Tenant #C2's PCP further stated typical recommended dosing of the Lorazepam medication for patients over 65 years of age is 1-2mg/day divided two to three times per day and noted Tenant #C2 had chronic kidney disease for which there is no dose adjustment. The PCP stated signs a patient may be on too high of a dose include but not limited to: sedation, dizziness, fatigue, confusion, with more serious side effects nursing should be aware of such as bradycardia, respiratory depression, ataxia, hypotension, syncope, and apnea. Review of incident reports on 5/29/26 revealed an incident report for Tenant #C2 dated 3/11/26 for an unwitnessed fall. The incident report noted staff reported Tenant #C2 had fallen and struck the back of his head on the entertainment center. The incident report noted Emergency Medical Services (EMS) were contacted and Tenant #C2 was transported to the emergency room (ER) via ambulance. A progress note dated 3/13/26 entered by Staff D noted Tenant #C2 returned from the hospital with a post sub-arachnoid hemorrhage. When interviewed on 6/11/26 at 12:15p.m. Health Care Coordinator (HCC) recalled entering the nursing office after hired and finding a handwritten document on the nursing desk that	A 122			

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A 122	Continued From page 28 stated "Lorazepam" at the top of the paper, and noted with Tenant #C2's initials. She recalled the paper noted each dosage of Tenant #C2's Lorazepam, including scheduled, every four hours, and prn being administered to Tenant #C2. The HCC stated she recalled it was a huge red flag as she looked at the paper and was concerned with the quantity he was getting. She noted it was as much as six times per day. The HCC recalled thinking Tenant #C2 had "a crazy amount of crap (medications) in him." When questioned if the large quantity of Lorazepam Tenant #C2 was being administered could have contributed to Tenant #C2's fall on 3/11/26, the HCC agreed it was possible. When asked if she felt Tenant #C2 had received adequate and appropriate care in regards to medication services, the HCC acknowledged someone should have been more aware and Tenant #C2 had probably not received adequate care and services. 3. Observations on 4/9/26 at 1:40p.m. revealed Tenant #5 has broken glasses on, screw and left lens out of frame. Observations on 4/17/26 at 4:30p.m. revealed Tenant #5 continued to wear broken glasses with the screw and left lens of the frame. The surveyor asked the Regional Operations Specialist (ROS) when Tenant #5 would get new glasses, when the ROS indicated she was unaware Tenant #5's glasses were broken. The ROS stated she would contact the tenant's power of attorney. Observations on 4/24/26 revealed Tenant #5 wore new glasses, fully intact. 4. The Program policy, Resident Rights, dated 5/15/24, indicated the residents received care,	A 122		

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A 122	Continued From page 29 treatment and services which were adequate and appropriate.	A 122		
A 150	481-67.5(2)e(1) Medications 481-67.5(231B,231C,231D) Medications. 67.5(2) Each program shall follow its own written medication policy, including the following: e. When medications are administered traditionally by the program: (1) The administration of medications will be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 481-Chapter 781. Injectable medications will be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or PA. This REQUIREMENT is not met as evidenced by: Based on interview and record review, at least four program staff administered medications prior to and/or without having completed a department-approved medication manager course for 4 of 4 tenants for whom medication administration records (MARs) were reviewed (Tenant #C1, Tenant #C2, Tenant #1, Tenant #3). Findings follow:	A 150		

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A 150	Continued From page 30 1. Record review on 5/11/26 of the program's Medication and Medication Administration-Iowa policy (revised 7/2025) revealed the Medication Administration section of the policy identified staff performing medication duties were trained and monitored, according to the DIAL requirement of an approved medication manager course. The policy further noted the nurse would delegate medication administration to Resident Assistants after they attended an approved medication management course, the Nurse watched them pass medications and felt they were competent. 2. Record review on 5/20/26, 5/21/26, and 5/26/26 of MARs revealed Staff G, Staff C, Staff H, and Staff I administered medications prior to and/or without having completed a department-approved medication manager course. 3. Record review revealed Staff G, a minor hired on 12/4/25 and terminated on 4/6/26. The program failed to provide a certificate of completion for Staff G of an approved medication manager course. Continued record review of MARs revealed Staff G, a minor, administered at least the following doses of medications: a. Tenant #C2's February 2026 MAR noted Staff G administered the following medications on 2/13/26: Buspirone 7.5 milligrams (mg), Terazosin 2mg and Trazodone 50mg. b. Tenant #C2's March 2026 MAR noted on 3/28/26 Staff G administered Buspirone 7.5mg at 8:00 pm and Terazosin 2mg.	A 150		

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A 150	Continued From page 31 c. Tenant #3's February 2026 noted on 2/13/26 Staff G administered Dicyclomine 20mg, Ipratropium 0.03%, Rosuvastatin 10mg, SF 5000 plus dental cream 1.1%, Tamsulosin 0.4mg, and Cranberry tab - 450mg. d. Tenant #1's February 2026 MAR noted on 2/13/26 Staff G administered Alprazolam 0.25mg, Metoprol 100mg, and Quetiapine 50mg. e. Tenant #C1's February 2026 noted on 2/13/26 Staff G administered Acetaminophen 500 mg, Antifungal Powder two percent, Cholestyramine Powder four gram packet, Tramadol HCL 50 mg, Trazodone 50 mg, and barrier cream. When interviewed on 5/11/26 at 3:18 p.m. the Health Care Coordinator (HCC) confirmed Staff G was not medication delegated or old enough to pass medication. 4. Record review revealed Staff C, hired on 12/5/25, completed a medication manager course on 5/5/26. Continued review of the following MARs revealed Staff C administered at least the following doses of medications prior: a. Tenant C2's February 2026 MAR noted Staff C administered the following medications: Allopurinol 100mg, Buspirone 7.5mg, Memantine HC Cap 14mg ER, Metoprol 25mg ER, and Bumetanide 0.5mg on February 10th, 11th, 13th, 14th, 15th, 16th, 18th, 27th Calcitriol 0.25mg on February 13th and 27th and Potassium Chloride 10meq ER on February 11th, 13th, 15th, and 27th	A 150		

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A 150	Continued From page 32 b. Tenant C2's March 2026 MAR noted Staff C administered the following medications: Allopurinol 100mg, Buspirone 7.5mg, Metoprol 25mg ER, Memantine HC Cap 14mg ER, and Bumetanide 0.5mg on March 3rd, 17th, 21st, 22nd, 24th, 26th Folic Acid 1mg, Jardiance 10mg, Multivitamin Tab, Preservision Cap, and Vitamin B-1 100mg on March 17th, 21st, 22nd, 24th, 26th Potassium Chloride 10meq ER on March 17th and 21st Ativan 0.25mg and Cefuroxime 500mg on March 17th Cephalexin 500mg on March 3rd Rexulti 0.25mg on March 21st, 22nd, 24th, 26th c. Tenant C2's April 2026 MAR noted Staff C administered the following: Allopurinol 100mg, Buspirone 7.5mg, Jardiance 10mg, Memantine HC Cap 14mg ER, Metoprol 25mg ER, and Rexulti 1mg on March 9th, 13th Bumetanide 0.5mg on March 13th, 20th, 21st, 23rd Folic Acid 1mg, Multivitamin, Vitamin B-1 100mg Tab on April 9th, 13th, 20th, 21st, 23rd Bumetanide 0.5mg and Cephalexin 500mg on April 9th Cephalexin 500mg on April 23rd Rexulti 2mg on April 20th, 21st, 23rd	A 150			

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A 150	Continued From page 33 d. Tenant #3's February 2026 MAR noted Staff C administered the following medications: Allopurinol 100mg, Arnuity Elpt inhaler 100mcg, Aspirin 81mg, Dicyclomine 20mg, Ipratropium 0.03% nasal, Loratadine 10mg, Metoprol 25mg ER, Pantoprazole 20mg, Senna docusate 50-8.6mg, SF 5000 plus dental cream 1.1%, Vitamin D3 50mcg, Diltiazem HCL ER 120mg, Duloxetine 60mg, Finasteride 5mg, Furosemide 20mg, Oxycodone 5mg, Pregabalin 100mg, Spironolact 25mg on February 10th, 11th, 13th, 14th, 15th, 16th, 18th, 19th, 20th, 23rd, 24th, 25th, 27th, 28th. Cranberry Tab 450mg and Culturelle on February 10th, 11th, 13th, 14th, 15th, 16th, 18th Furosemide 20mg and Icy Hot Pad 4% topical patch on February 10th, 11th, 13th, 14th, Metamucil gummy 3.4g on February 10th Dicyclomine 20mg on February 25th and 28th PRN Acetaminophen 500mg on February 25th e. Tenant #3's March 2026 MAR noted Staff C administered the following medications: Allopurinol 100mg, Arnuity Elpt inhaler 100mcg, Aspirin 81mg, Dicyclomine 20mg, Diltiazem HCL ER 120mg, Duloxetine 60mg, Ipratropium 0.03% nasal, Loratadine 10mg, Metoprol 25mg ER, Duloxetine 60mg, Metoprol 25mg ER, Oxycodone 5mg, Pantoprazole 20mg, Senna docusate 50-8.6mg, SF 5000 plus dental cream 1.1%, and Vitamin D3 50mcg were administered March 1st, 3rd, 4th, 5th, 6th, 9th, 10th, 11th, 12th, 14th, 15th, 18th, 19th, 20th, 21st, 22nd, 23rd, 24th, 26th, 27th, 30th, and 31st.	A 150		

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A 150	Continued From page 34 Dicyclomine 20mg and lpratropium 0.03% nasal on the dates of the 3rd, 9th, 15th, 21st, 22nd, 23rd, 28th and 29th, 31st. Dicyclomine 20mg, Donepezil 10mg, lpratropium 0.03%, Tamsulosin 0.4mg, Cephalexin 500mg, Rosuvastatin 10mg, Warfarin 4mg on March 28th and 29th Finasteride 5mg on March 9th, 10th, 11th, 12th, 14th, 15th, 18th, 19th, 20th, 21st, 22nd, 23rd, 24th, 26th, 27th, 30th and 31st. Furosemide 40mg on March 27th, 30th and 31st. SF 5000 plus dental cream 1.1% on March 29th. Cephalexin 500mg on March 26th and 27th, 30th and 31st. Cranberry Tab 450mg and Culturelle on March 6th, 9th, 14th, 18th, 20th, 21st, 22nd, 23rd, and 30th. Pregabalin 100mg on March 14th, 15th, 18th, 19th, 20th, 21st, 22nd, 23rd, 24th, 26th, 27th, 30th and 31st. Spironolact 25mg on March 1st. f. Tenant #1's February 2026 MAR noted Staff C administered the following medications: Allopurinol 100mg on February 10th and 11th Allopurinol 100mg on February 13th, 14th, 15th, 16th, 18th, 19th, 20th, 23rd, 24th, 25th, 27th, and 28th. Atorvastatin 20mg, Duloxetine 30mg, Furosemide	A 150			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

LAWTON SENIOR LIVING **200 E CHAR-MAC DR**
LAWTON, IA 51030

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A 150	Continued From page 35 20mg, Metoprol 100mg, Quetiapine 25mg, Spironolact 25mg, Vitamin B-12 1000mcg on February 10th, 11th, 13th, 14th, 15th, 16th, 18th, 19th, 20th, 23rd, 24th, 25th, 27th, and 28th. g. Tenant #1's March 2026 MAR noted Staff C administered the following medications: Allopurinol 100mg, Atorvastatin 20mg, Furosemide 20mg, Metoprolol 100mg, Quetiapine 25mg, Spironolact 25mg, Vitamin B-12 1000mcg, Duloxetine 30mg on March 1st, 3rd, 4th, 5th, 6th, 9th, 10th, 12th, 14th, 15th, 18th, 19th, 20th, 21st, 22nd, 23rd, 24th, 26th, 27th, 30th, and 31st. Quetiapine 50mg on March 28th and 29th Alprazolam 0.25mg on March 28th h. Tenant #1's April 2026 MAR included the administration of the following medications: Allopurinol 100mg, Atorvastatin 20mg, Quetiapine 25mg, Furosemide 20mg, Metoprol 100mg, Quetiapine 25mg, Spironolact 25mg, Vitamin B-12 1000mcg on April 3rd, 6th, 8th, 9th, 11th, 12th, 13th, 15th, 16th, 17th, 22nd, 27th, 29th, and 30th Duloxetine 30mg on April 15th, 16th, 17th, 22nd, 27th, 29th and 30th Quetiapine 50mg, Alprazolam 0.25mg on April 17th Duloxetine 30mg on April 3rd i. Tenant #1's May 2026 MAR revealed Staff C administered at least the following doses of medications prior to her Medication Management Certificate on 5/5/26:	A 150		

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NAME OF PROVIDER OR SUPPLIER LAWTON SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 200 E CHAR-MAC DR LAWTON, IA 51030		
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A 150	Continued From page 36 Allopurinol 100mg, Atorvastatin 20mg, Duloxetine 30mg, Furosemide 20mg, Metoprol 100mg, Quetiapine 25mg, Spironolact 25mg, Vitamin B-12 1000mcg on May 1st, 2nd and 4th Acetamin ER on 650mg on May 1st When interviewed on 5/20/26 at 3:05pm the HCC and Resident Services Coordinator (RSC) were asked how Staff C passed medications beginning in February of 2026 without having completed a Medication Management course until 5/5/26. The HCC expressed awareness and indicated she believed there was an issue with Staff C's medication management course skills checklist. The HCC reported Staff C signed off one set in January 2026, but was never signed by an RN. She indicated as the HCC, she had then been signing the skills checklists, but the Iowa Assisted Living Association who provided the course indicated she, as an Licensed Practical Nurse (LPN), could not sign. She indicated both she and the management corporation were unaware LPNs could not sign, so now the Regional Nurse Specialist co-signed the medication management course skills checklists. 5. Record review revealed Staff H had a hire date of 12/16/24. The program provided no certificate of completion for Staff H of an approved medication manager course. Review of the following MARs revealed Staff H administered at least the following doses of medications: a. Tenant #C2's February 2026 MAR indicated Staff H administered the following on 2/12/26: Allopurinol 100mg, Buspirone 7.5mg, Memantine HC Cap 14mg ER, Metoprol 25mg ER,	A 150		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/05/2026
NAME OF PROVIDER OR SUPPLIER LAWTON SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 200 E CHAR-MAC DR LAWTON, IA 51030		
(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 150	Continued From page 37 Bumetanide 0.5mg, and 12:00pm - Bumetanide 0.5mg. b. Tenant #3's February 2026 MAR indicated Staff H administered the following on 2/12/26: Allopurinol 100mg, Arnuity Elpt inhaler 100mcg, Aspirin 81mg, Dicyclomine 20mg, Ipratropium 0.03% nasal, Loratadine 10mg, Metoprol 25mg ER, Pantoprazol 20mg, Senna docusate 0-8.6mg, SF 5000 plus dental cream 1.1%, Vitamin D3 50mcg, Cranberry Tab 450mg, Culturelle, Diltiazem HCL ER 120mg, Duloxetine 60mg, Finasteride 5mg, Furosemide 20mg, Pregabalin 100mg c. Tenant #3's March 2026 MAR indicated Staff H administered the following on 3/11/26: Dicyclomine 20mg, Donepezil 10mg, Ipratropium 0.03% nasal, Rosuvastatin 10mg, SF 5000 plus dental cream 1.1%, Tamsulosin 0.4mg, Melatonin 5mg, and Warfarin 3.5T 7mg. d. Tenant #1's February 2026 MAR indicated Staff H administered the following on 3/12/26: Allopurinol 100mg, Atorvastatin 20mg, Duloxetine 30mg, Furosemide 20mg, Metoprol 100mg, Quetiapine 25mg, Spironolact 25mg, and Vitamin B-12 1000mcg. e. Tenant #1's March 2026 MAR indicated Staff H administered the following on 3/11/26: Metoprol 100mg, Quetiapine 50mg, and Alprazolam 0.25mg f. Tenant #1's April 2026 MAR indicated Staff H administered the following on 4/25/26 and 4/26/26: Allopurinol 100mg, Atorvastatin 20mg, Duloxetine 30mg, Furosemide 20mg, Metoprol 100mg, Quetiapine 25mg, Spironolact 25mg, and Vitamin B-12 1000mcg	A 150			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/05/2026
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A 150	Continued From page 38 During a staff interview on 5/20/26 at 3:05pm with the HCC and RSC, the HCC confirmed Staff H would not have been trained during the time reviewed of February 2026 to April 2026. 6. Record review revealed Staff I had a hire date of 1/21/26. The program provided no certificate of completion for Staff I of an approved medication manager course. Review of the following MARs revealed Staff I administered at least the following doses of medications: a. Tenant #C2's March 2026 MAR indicated Staff I administered the following on 3/3/26: Buspirone 7.5mg, Terazosin 2mg, Cephalexin 500mg, Trazodone 50mg b. Tenant #3's March 2026 MAR indicated Staff I administered the following on 3/3/26: Dicyclomine 20mg, Ipratropium 0.03% nasal, Rosuvastatin 10mg, SF 5000 plus dental cream 1.1%, Tamsulosin 0.4mg, Cranberry Tab 450mg, Donepezil 10mg, Melatonin 5mg, and Warfarin 3.5T (7mg) c. Tenant #1's March 2026 MAR indicated Staff I administered the following on 3/3/26: Alprazolam 0.25mg, Metoprol 100mg, and Quetiapine 50mg During an interview on 5/20/26 at 3:05pm the HCC and RSC were unaware Staff I documented as having administered any medications. The RSC confirmed Staff I was not trained as she was not old enough to take the medication manager course.	A 150		

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A 152	Continued From page 39	A 152		
A 152	481-67.5(2)e(3) Medications 481-67.5(231B,231C,231D) Medications. 67.5(2)?Each program shall follow its own written medication policy, including the following: e. When medications are administered traditionally by the program: (3) Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or PA. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to administer medications as prescribed for 2 of 13 tenants reviewed (Tenant #C2 and Tenant #4). Findings follow: 1. Record review on 5/11/26 revealed Tenant #C2 admitted to the program on 11/24/25. A review of Tenant #C2's physician orders, dated 12/10/25, included an order for Trazodone 50mg, 1 tablet by mouth one time per day at bedtime. A physician order dated 3/10/26 noted to discontinue Trazodone. Continued record review revealed Tenant #C2's March 2026 Medication Administration Record (MAR) documented 50mg Trazodone was administered by program staff on 3/10/26, 3/11/26, 3/13/26, 3/14/26, 3/15/26, 3/16/26, and 3/17/26. Further review of the MAR revealed Trazodone 50mg was undocumented on 3/18/26	A 152		

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A 152	Continued From page 40 and 3/19/26, before being discontinued on 3/20/26. Record review on 5/29/26 revealed Tenant #C2's incident report for an unwitnessed fall, dated 3/11/26. The incident report noted staff reported Tenant #C2 did not act like his normal self. The report also noted that the family of Tenant #C2 had called and requested clarification of medications being administered to Tenant #C2. The family informed Staff F (the Triage Nurse) that the Trazodone was supposed to be discontinued and had questions pertaining to that. The incident report noted Staff F instructed Tenant #C2's family to follow up with Tenant #C2's primary care provider (PCP) and community nurse regarding any medication concerns. Staff F then noted she reviewed digital documents and found no discontinuation orders for the Trazodone, but she notified Tenant #C2's PCP via fax and the Director/HCC via email. The incident report listed the community nurse as Staff D. When interviewed on 6/11/26, the Health Care Coordinator (HCC) confirmed program staff continued to document Tenant #C2's Trazodone as administered following the discontinuation date. She stated physician orders do not necessarily arrive by fax; some arrive via email directly to the HCC so nurses are able to access them even when they are out of the building and can still upload them into the system. She stated the 3/10/26 discontinuation order for Tenant #C2's Trazodone may have been sent to RN Staff D's email, who assisted with coverage/training at the time. The HCC stated no orders were yet going to her own email at the time of Tenant #C2's 3/10/26 discontinuation order.	A 152			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/05/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LAWTON SENIOR LIVING

**200 E CHAR-MAC DR
LAWTON, IA 51030**

(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 152	Continued From page 41 Record review on 5/19/26 revealed Tenant #C2's March 2026 Medication Administration Record (MAR) included two Lorazepam entries: *Lorazepam 0.5mg, take 1 tablet by mouth every 6-8 hours as needed for anxiety with an order start date of 3/3/26 *Ativan (Lorazepam) 0.5mg tablet, take 0.25mg by mouth three times per day every day at 10:00am, 1:00pm, and 4:00pm. Continued review of the March 2026 MAR revealed the following doses had been administered: On 3/6/26: *PRN doses administered at 12:15am, 6:17am, and 11:36pm *Doses administered at scheduled times of 10:00am, 1:00pm, and 4:00pm On 3/7/26: *PRN dose administered at 5:40am *Doses administered at scheduled times of 10:00am, 1:00pm, and 4:00pm On 3/8/26: *No PRN doses administered *Doses administered at scheduled times of 10:00am, 1:00pm, and 4:00pm On 3/9/26: *PRN doses administered at 6:30am and 11:32pm *Doses administered at scheduled times of 10:00am, 1:00pm, and 4:00pm On 3/10/26: *PRN doses administered at 5:45am and 11:13pm *Doses administered at scheduled times of 10:00am, 1:00pm, and 4:00pm	A 152		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/05/2026
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

LAWTON SENIOR LIVING

**200 E CHAR-MAC DR
LAWTON, IA 51030**

(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 152	Continued From page 42 On 3/11/26: *PRN dose administered at 5:39am *Doses administered at scheduled times of 10:00am, 1:00pm, and 4:00pm On 3/12/26: *Both the PRN and scheduled entries noted LOA for Leave of Absence On 3/13/26: *The PRN entry was noted LOA for Leave of Absence *Dose administered at scheduled time of 4:00pm On 3/14/26: *PRN dose administered at 11:34:00pm *The scheduled dose entries were noted LOA for Leave of Absence On 3/15/26: *PRN dose administered at 7:50pm *Doses administered at scheduled times of 10:00am, 1:00pm, and 4:00pm On 3/16/26: *PRN dose administered at 2:15am * Doses administered at scheduled times of 10:00am, 1:00pm, and 4:00pm On 3/17/26: *No PRN doses administered *Doses administered at scheduled times of 10:00am, 1:00pm, and 4:00pm On 3/18/26: *PRN doses administered at 12:05am and 11:57pm *Doses administered at scheduled times of	A 152		

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A 152	Continued From page 43 10:00am, 1:00pm, and 4:00pm On 3/19/26: *PRN dose administered at 11:28pm *Doses administered at scheduled times of 10:00am, 1:00pm, and 4:00pm The scheduled Ativan 0.25mg by mouth three times per day was then noted as discontinued on the MAR as of 3/21/26. Record review revealed physician orders prescribed 3/2/26 confirmed the PRN dose every 6-8 hours, but the Regional Nurse Specialist confirmed via email on 5/29/26 no Ativan 0.25mg order was on file at the program. Record review revealed a narcotic count sheet for Tenant #C2 labeled Lorazepam 0.5mg, 1 tab every 6-8 hours as needed, which included an entry on 3/8/26 at 11:30am signed out as administered by Staff E. The entry noted the amount given as ½, with the total count going from 18 tablets to 17 ½ tablets. Staff E further noted, "per (Staff D)." This was the only entry documenting administration of a ½ tablet (0.25mg) across all Tenant #C2's narcotic count sheets reviewed for March. Further review of Tenant #C2's narcotic count sheets failed to reveal a scheduled dose of Ativan (Lorazepam) 0.25mg. When interviewed on 6/3/26 at 3:37pm, Staff C stated she could not recall if Tenant #C2 had Ativan medication bubble packs with ½ tablets (0.25mg), but confirmed if there had been, the cards would have had a pharmacy label printed on the top of the card. When interviewed on 6/4/26 at 12:07pm, Staff B	A 152			

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A 152	Continued From page 44 recalled several days when she would have administered Tenant #C2's Lorazepam and remembered there was more than one bubble pack. She believed at one point the scheduled Lorazepam pack ran out and staff began using from the PRN card (0.5mg). Staff B could not recall any split pills and believed it was always a full tablet administered. On 6/1/26 the Pharmacy Manager of Tenant #C2's providing pharmacy noted via email communications at 1:15pm, the pharmacy never received an order scheduled 0.25mg Ativan (Lorazepam) for Tenant #C2's. The Pharmacy Manager further confirmed at 2:14pm, via email communication, if the pharmacy received an order for 0.25mg Ativan (Lorazepam), the pharmacy would have used a 0.5mg tablet and pre-split the tablet and packaged a ½ tablet (0.25mg) into each bubble of the dosing card. On 6/15/26, via letter response, Tenant #C2's PCP confirmed she prescribed the following: *3.2.26 approving a faxed request from Staff D for Lorazepam 0.5mg every 4 hours. *3.2.26 Lorazepam 0.5mg every 6-8 hours as needed. (The PCP confirmed this order was not in addition to the previous Lorazepam order approved earlier in the day.) *3.5.26 Lorazepam 0.5mg, changing the order from PRN to TID every 8 hours. (The PCP confirmed this order did not state specific times, just should be 8 hours apart.) Tenant #C2's PCP further stated typical recommended dosing of the Lorazepam medication for patients over 65 years of age is 1-2mg/day divided two to three times per day and	A 152		

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A 152	Continued From page 45 noted Tenant #C2 had chronic kidney disease for which there is no dose adjustment. The PCP noted signs a patient may be on too high of a dose included: sedation, dizziness, fatigue, confusion. She further noted more serious side effects nursing should be aware of included: bradycardia, respiratory depression, ataxia, hypotension, syncope, and apnea. When interviewed on 6/11/26 at 12:15pm the Health Care Coordinator (HCC) was asked to clarify the discrepancy in orders versus administration of Tenant #C2's Trazodone and Lorazepam medications. The HCC recalled entering the nursing office after hire and found a handwritten document on the nursing desk that stated "Lorazepam" at the top of the paper, and Tenant #C2's initials. She recalled on the paper was each dosage of Lorazepam administered to Tenant #C2, including scheduled, every four hours, and PRN. The HCC stated she recalled it was a huge red flag as she looked at the paper and was concerned with the quantity he was getting. She noted it was as much as six times per day. The HCC recalled thinking Tenant #C2 had "a crazy amount of crap (medications) in him." Record review on 6/17/26 noted a physician's order provided by Tenant #C2's PCP. The order, dated 3/5/26, instructed the program to adjust the dosing of Tenant #C2's current 0.5mg Lorazepam to "please give the Lorazepam 0.5mg tablet to this patient every 8 hours - on a schedule until he is seen at my office on 3/9/26. This is the recommendation of the ER Dr that he (saw) today at Unity Point St. Lukes-South campus/ER." Record review on 5/19/26 revealed the March 2026 Medication Administration Record (MAR) for	A 152		

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A 152	Continued From page 46 Tenant #C2 documented: On 3/6/26: *PRN doses administered at 12:15am, 6:17am, and 11:36pm *Doses administered at scheduled times of 10:00am, 1:00pm, and 4:00pm On 3/7/26: *PRN dose administered at 5:40am *Doses administered at scheduled times of 10:00am, 1:00pm, and 4:00pm On 3/8/26: *No PRN doses administered *Doses administered at scheduled times of 10:00am, 1:00pm, and 4:00pm On 3/9/26: *PRN doses administered at 6:30am and 11:32pm *Doses administered at scheduled times of 10:00am, 1:00pm, and 4:00pm When asked to provide documentation and confirmation of all orders for Tenant #C2 from 12/10/25 to 4/22/26, the program provided medication orders dated 12/10/25, 2/6/26, 3/2/26, 3/10/26, 3/13/26, 3/20/26, 3/23/26, 4/1/26, and 4/22/26, but failed to provide documentation of the physician's order dated 3/5/26 or confirm it was on file with the program. 2. Observations on 6/1/26 at 1:36pm revealed Tenant #4 walked the path around the program unattended by staff. At 1:41pm noted Tenant #4 walked the path around the program unattended by staff. Record review on 6/1/26 revealed Tenant #4 was	A 152		

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A 152	Continued From page 47 admitted to the program on 5/3/26. Record review on 6/17/26 noted a physician's order provided by Tenant #4's provider through Curana. The order, dated 5/18/26, instructed the program that Tenant #4 needed to be accompanied by staff when walking outside. When interviewed on 7/16/26 at 2:02 p.m. the Regional Nurse Specialist indicated she was not able to answer questions overseeing the Program at Lawton Senior Living. She indicated the Health Care Coordinator was in charge since the delegation changes in Assisted Living rules.	A 152		
A 191	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the Program failed to consistently provide an adequate number of appropriately trained staff to meet tenants' needs. This affected 9 of 9 tenants residing in memory care and potentially affected all tenants residing at the Program. Findings follow: 1. Observations on 4/9/26 revealed 27 tenants resided at the Program, including 9 tenants in the memory care unit of the Program. Observations on 4/10/26 at 2:30pm revealed one staff on the memory care unit.	A 191		

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A 191	Continued From page 48 When interviewed on 4/10/26 at 7:00pm, the Regional Director of Operations (RDO) reported they would have two staff on the assisted living unit, two staff on the memory care unit, and a supervisor onsite 24 hours a day, following concerns expressed by the Department regarding adequate staffing. Record review revealed the following: a. Tenant #C1's service plan, dated 10/30/25, included: Fall interventions of reminders to ask for assistance when attempting to sit or stand; staff assistance with toileting in case of syncopal episode; staff assistance with medication administration; extensive assistance with dressing; total assistance with toileting and peri care; encouragement to drink fluids between bites; may require assistance with feeding; total assistance with activities; total assistance with grooming; total assistance with evacuation; total assistance with bathing daily; frequent supervision or oversight. Record review on 5/05/26 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.	A 191		

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NAME OF PROVIDER OR SUPPLIER LAWTON SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 200 E CHAR-MAC DR LAWTON, IA 51030		
(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 191	Continued From page 49 Continued review on 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. When interviewed on 6/26/26 at 8:15 a.m. Staff G reported he worked on 4/4/26, the 2:00 p.m. to 10:00 p.m. shift in the memory care unit by himself with ten tenants. 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. b. Tenant #C2's service plan, dated 3/13/26, included: frequent behavior issues including agitation, physical aggression, verbal aggression, attention-seeking behavior; history of wandering; assistance with toileting; fall interventions including reminders to use assistive devices; staff assistance with medication administration; visual safety checks; assistance with dressing; assistance with grooming; total assistance with evacuation; difficulty sleeping. c. Tenant #2's service plan, dated 4/30/26, included: aggression and agitation; safety checks; refusing to stay in bed; assistance with medication administration; extensive assistance with dressing; extensive assistance with toileting; assistance cutting up food and opening packages; extensive assistance with grooming; total assistance with bathing; visual checks. d. Tenant #5's service plan, dated 3/18/26, included: cue & standby assistance with bathing	A 191		

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LAWTON SENIOR LIVING **200 E CHAR-MAC DR**
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A 191	Continued From page 50 daily; visual/safety checks; occasional disruptive behavior; aggression, or socially inappropriate behavior; moderate wandering issues e. Tenant #8's service plan, dated 2/16/26, included: fall interventions, including reminders to use walker when ambulating and encouraging tenant to call for help prior to transfer and wait for assistance; staff administration of medications; extensive assistance with toileting due to incontinence; moderate assistance with meals; extensive assistance with grooming; extensive assistance with bathing daily; total assistance with transferring; occasional behavior issues including disruptive and aggressive behavior and wandering issues; moderate assistance with ambulation; visual and safety checks f. Tenant #9's service plan, dated 6/30/25, included: staff assistance with medication administration; moderate wandering issues. See Iowa Administrative Code 481 Chapter 69.23(1)c(1) for additional information. 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 Health Care Coordinator (HCC) directed staff to lock the tenants bedroom doors. Staff O also indicated Tenant #9 made sexual comments to her as well. Staff L indicated Tenant #9 was aroused at lunch and she did not know if it was in his service plan. Staff L's main concern was she did not want him to hurt another tenant. From 5:43 p.m. to 5:48 p.m. Staff L and Staff O were in the dining room. Tenant #9 was in his room with his door cracked open. Tenant #2, Tenant #6, and Tenant #8,	A 191		

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A 191	Continued From page 51 female tenants' doors remained unlocked with them present. 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. Continued observations on 5/5/26 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. When interviewed on 5/5/26 at 6:35 p.m., Staff Q indicated Tenant #9 had sexual behaviors toward staff as long as she worked there; however, the behavior was not addressed in his service plan and no direction was provided. Staff Q told him to go to his room when he was inappropriate. Observations on 5/06/26 at 5:55 a.m. revealed Staff R told the other staff on the memory care unit to keep all the tenants doors locked and staff in the hallway when Tenant #9 was out of his room. Tenant #10's service plan, dated 3/19/26, included: encouragement to ask for assistance before picking items up off the floor; visual/safety checks; occasional disruptive, aggressive or socially inappropriate behavior; wandering issues; moderate assistance with evacuation; assistance with TED hose and encouragement to elevate legs three times daily.	A 191		

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A 191	Continued From page 52 On 4/9/26 at 1:40pm staff reported Tenant #10 could be aggressive at times, though it was better with recent medication changes. g. Tenant #11's service plan, dated 8/13/25, included: staff administration of medications; moderate assistance with dressing; assistance with putting compression socks on in the morning and removing in the evening; moderate assistance with evacuation; extensive assistance with bathing daily; frequent behavior issues including wandering and a history of leaving the immediate area; getting lost; or becoming combative about returning, requiring supervision. h. Tenant #12's service plan, dated 4/13/26, included: verbal prompts/cues for toileting tasks; extensive wandering issues, including leaving immediate area and a history of getting lost or being combative about returning, requiring supervision due to elopement from the Program; moderate assistance with bathing daily. When interviewed on 6/26/26 at 8:06 a.m. Staff G reported typically one staff worked in the memory care unit with 10 tenants.. When interviewed on 6/25/26 at 11:10 a.m. Staff V reported one staff could not adequately care for all tenants in the memory care unit. He reported the inappropriate sexual behavior of Tenant #9, as well as the aggressive behaviors of Tenant #10 and Tenant #C2 made it more difficult. Tenant #C2 would try to hit, kick and spit on others. Mealtime was also difficult with one staff, as some tenants would stay in their rooms, while others would eat in the dining room. He stayed in the dining room because tenants would steal each other's food. He was not able to help tenants in their rooms.	A 191		

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A 191	Continued From page 53 When interviewed on 6/12/26 at 9:03 a.m. the Resident Services Coordinator (RSC) stated they typically scheduled on staff in the assisted living portion of the Program, and one in the memory care portion. He stated it was difficult for staff, as that required a lot of one person to complete. Some days there were tenants in the assisted living portion that would page every 5-10 minutes for assistance. Staff in the memory care would frequently require assistance, leaving the assisted living portion unattended for a period of time. When interviewed on 6/11/26 at 1:03 p.m. the Health Care Coordinator reported prior to 4/3/26, the Program assigned one staff to the assisted living portion of the Program, and one staff to the memory care portion, as well as a medication passer. 2. Record review on 5/20/26, 5/21/26, and 5/26/26 for Medication Administration Records revealed Staff G, Staff H, and Staff I administered medications prior to and/or without having completed a department-approved medication manager course. See Iowa Administrative Code 481 Chapter 67.5(2)e(1) for additional information. a. Record review of tenant medication administration records (MARs) revealed Staff G, 16 years old, administered medications to tenants on at least the following dates: 2/13/26 and 3/28/26 to Tenant #C2, Tenant #3, Tenant #1, and Tenant #C1. Continued record review revealed Staff G was	A 191		

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A 191	Continued From page 54 hired on 12/4/25 and terminated on 4/6/26. The program failed to provide a certificate of completion for Staff G of an approved medication manager course. Additional record review revealed skills delegations for Staff G initialed, signed, and dated by him on 12/22/25. The documentation failed to include nurse initials or signature indicating training completed. Further review of delegations failed to reveal training completed regarding medication administration. When interviewed on 5/11/26 at 3:18 p.m. the Health Care Coordinator (HCC) confirmed Staff G was not medication delegated or old enough to pass medication. b. Record review revealed Staff H administered medications to tenants on at least the following dates: 2/12/26, 3/11/26, 3/12/26, and 4/25/26 to Tenant #C2, Tenant #3, and Tenant #1. Continued record review failed to provide documentation of Staff H's completion of an approved medication manager course. Additionally, documentation was not provided to indicate completion of training regarding medication administration. When interviewed on 5/20/26 at 3:05 p.m. the HCC confirmed Staff H was not trained on medication administration. c. Record review revealed Staff H administered medications to tenants on at least 3/3/26. Continued record review failed to provide documentation of Staff I's completion of an approved medication manager course.	A 191		

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A 191	Continued From page 55 Additionally, documentation was not provided to indicate completion of training regarding medication administration. During a staff interview on 5/20/26 at 3:05pm the HCC and RSC were unaware Staff I documented as having administered any medications. The RSC confirmed Staff I was not trained as she was not old enough to take the medication manager course.	A 191		
A 192	481-67.9(2) Staffing 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to implement emergency procedures regarding clinical communication hierarchy and fall prevention and reduction. This affected 1 of 2 discharged tenants (Tenant #C1). 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	A 192		

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A 192	Continued From page 56 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	A 192			

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A 192	Continued From page 57 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	A 192		

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A 192	Continued From page 58 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	A 192		

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A 192	Continued From page 59 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.	A 192		

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A 192	Continued From page 60 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 left 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	A 192			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 192	Continued From page 61 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.	A 192		
A 193	481-67.9(3) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(3) Documentation. The program shall have training records and staffing schedules on file and maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the Program failed to maintain thorough and accurate training records to reflect completion of training received by program staff on nurse-delegated	A 193		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

LAWTON SENIOR LIVING **200 E CHAR-MAC DR**
LAWTON, IA 51030

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A 193	Continued From page 62 procedures. This pertained to 9 of 17 staff delegations reviewed. Findings follow: - Record review on 6/11/26 revealed Staff G, a universal worker, was hired 11/30/25. Continued record review revealed skill delegation for Staff G, initialed, signed, and dated 12/22/25, by Staff G. - The document failed to include initials, signature, or date from a delegating nurse. - Record review revealed an employee demographic information form for Staff Z noted her hire date as 12/29/25. Continued record review revealed skills delegations for Staff Z, initialed and signed by Staff Z, dated 4/2 (no year provided). - Record review revealed demographic information for Staff AA indicated she was hired by the Program 8/30/24. Continued record review revealed skills delegations for Staff AA, initialed and signed by Staff AA, dated 4/2. The document failed to provide a year of completion. - Record review revealed a staff list provided by the Program documented Staff BB hired by the Program 3/21/24. Continued record review revealed skills delegation completed by Registered Nurse CC on 4/30; however, no year of completion was provided. - When requested, the Regional Director of Operations reported Staff Y was hired by the Program 5/11/26. Continued record review revealed Staff Y completed skills delegation with the HCC on 5/14; however, the document failed	A 193		

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A 193	Continued From page 63 to provide a year of completion. 6. Record review revealed a staff list provided by the Program documented Staff Q hired by the Program 10/16/25. Continued record review revealed Staff Q completed skills delegation with the HCC on 4/2; however, the document failed to provide a year of completion. 7. Record review revealed a staff list provided by the Program documented Staff T hired by the Program 1/20/26. Continued record review revealed Staff T completed skills delegation with the HCC on 4/2; however, the document failed to provide a year of completion. 8. Record review revealed the Resident Services Coordinator completed skills delegation with the HCC on 3/31; however, the document failed to provide a year of completion, name or signature of the delegating nurse. 9. Record review revealed a staff list provided by the Program documented Staff I hired by the Program 1/21/26. Continued record review revealed Staff I completed skills delegation with the HCC on 3/31; however, the document failed to provide a year of completion. 10 When interviewed on 7/22/26 at 1:00pm the Regional Director of Clinical Operations stated as the supervising Registered Nurse (RN), she would expect that the year be listed on the checklist along with the month and day the training was completed. She further stated she would expect that a full date, including month, date, and year, would be included along with the signatures of the staff and delegating nurse at the bottom of the form. The Regional Director of Clinical Operations confirmed there were no	A 193		

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A 193	Continued From page 64 additional mechanisms to confirm the dates training was completed.	A 193		
A 195	481-67.9(4)a Staffing 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: a. The program's newly hired nurse will within 60 days of beginning employment as the program's nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the Program failed to ensure delegations were completed by the new delegating nurse within 60 days of hire. This pertained to 3 of 17 staff delegations reviewed (Staff B, Staff H, and Staff BB). Findings follow: 1. Record review revealed the staff list provided by the program noted the Health Care Coordinator, an LPN, hired by the Program 3/4/26. 2. Record review revealed Staff H, hired by the Program 12/16/24. Continued record review revealed skills delegation completed by the Health Care Coordinator (HCC) on 5/4/26.	A 195		

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A 195	Continued From page 65 2. Record review revealed Staff BB, hired by the Program 3/21/24. Continued record review revealed skills delegation completed by Registered Nurse CC on 4/30; however, no year of completion was provided. Further record review failed to reveal delegations completed by the HCC within 60 days of hire. 3. Record review revealed a staff list provided by the Program documented Staff B hired by the Program 9/11/24. Continued record review revealed Staff B completed skills delegation with Staff D (RN) on 1/29/26. Further record review failed to reveal delegations completed by the HCC within 60 days of hire. 4. When interviewed on 7/2/26 at 1:00 p.m. the Regional Director of Clinical Operations confirmed the HCC was the delegating nurse for the Program.	A 195		
A 196	481-67.9(4)b Staffing 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: b. Within 30 days of beginning employment, all program staff will receive training by the program's nurse(s). This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the	A 196		

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A 196	Continued From page 66 Program failed to ensure all Program staff received training from the Program's nurse within 30 days of beginning employment. This pertained to 1 of 17 staff reviewed. Finding follows: Record review revealed Staff G began employment 12/4/25. Continued record review revealed "Skills Delegation" with each individual skill initialed by Staff G and dated 12/22/25. Further review failed to reveal a nurse's initials for each individual skill and no signature from a nurse. Additional record review revealed a New Employee Shadow Checklist, reviewed skills included in the document "Skills Delegation". Staff G initialed and dated each skill 3/31/26. Staff G signed the documented and dated 3/31/26. The Health Care Coordinator (HCC) also initialed each skill, signed and dated the documented 3/31/26. When interviewed on 7/22/26 at 1:00 p.m. the Regional Director of Clinical Operations confirmed she expected the skills checklists to be completed with date and initials of the staff and delegating nurse to indicate completion.	A 196			
A 200	481-67.9(4)f Staffing 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	A 200			

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A 200	Continued From page 67 shall include the following: f. Services will be provided to tenants in accordance with the training provided. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, program staff failed to provide medication administration services to tenants in accordance with the training provided for 2 of 3 tenants observed during medication administration (Tenant #2 and Tenant #3). Findings follow: 1. Record review on 5/5/26 revealed Tenant #2 admitted to the program on 3/30/25. The 4/30/26 service plan for Tenant #2 identified the need for "Staff to Administer Medications." During observation of medication administration on 5/14/26 at 11:40am with Staff B, Staff B entered Tenant #2's room where Tenant #2's spouse was also present. Staff B stated the purpose of needing to administer medication. Staff B washed her hands, unlocked the medication cabinet, reviewed the electronic medication administration record (eMAR) and compared it with the medication package labeling. Staff B dispensed one tablet of 200 milligrams (mg) Quetiapine for Tenant #2 into a medication cup. As Staff B approached Tenant #2, Tenant #2's spouse put his hand out towards Staff B, and Staff B handed the medication cup with the Quetiapine to Tenant #2's spouse, without stating she was responsible to administer the medication. Tenant #2's spouse tipped the medication cup and dispensed the Quetiapine into his own unwashed hand, approached Tenant	A 200		

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**200 E CHAR-MAC DR
LAWTON, IA 51030**

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A 200	Continued From page 68 #2, then placed the Quetiapine tablet directly into Tenant #2's mouth and brought a water bottle up to Tenant #2's mouth instructing her to drink. Tenant #2's spouse turned to Staff B and indicated Tenant #2 swallowed the medication. Staff B documented as administered. During an interview on 6/10/26 at 11:50am, the Health Care Coordinator (HCC) indicated she had a copy of Staff B's most recent re-delegations related to medication administration conducted on 5/26/26, but could not locate Staff B's original delegations from the time she originally completed the Medication Management Course on 10/22/24. Review of Staff B's medication administration delegation skills checklist revealed Staff B's training topics included Medication Management and Oral Medication Administration. 2. Record review on 5/5/26 revealed Tenant #3 admitted to the program on 11/5/25. The 4/29/26 service plan for Tenant #3 identified the need for "Staff to Administer Medications." Observations of medication administration on 5/19/26 at 2:04pm with Staff C revealed Staff C entered Tenant #3's room and stated the purpose of needing to administer medication. Staff C washed her hands, unlocked the medication cabinet, reviewed the eMAR in comparison with the medication package labeling. Staff C dispensed one tablet of 20mg Dicyclomine into a medication cup, administered to the tenant with water, and ensured the tenant swallowed. The eMAR instructed to instill one spray of Ipratropium 0.0.3% into each nostril three times per day. Staff C then handed Tenant #3 the nasal	A 200		

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A 200	Continued From page 69 applicator of Ipratropium 0.03% and allowed Tenant #3 to self-administer the Ipratropium. Staff C documented as administered. Review on 5/20/26 of Staff C's medication delegation training revealed three delegation packets: a. 12/22/25, unsigned by a Registered Nurse (RN) b. 2/5/26, signed by RN, Staff D c. dated simply as "5/5" with no year and signed by the HCC, an LPN, employed in 2026, which coincided with Staff C's certificate of completion for the Medication Management Course on 5/5/26. Review of Staff C's medication administration delegation skills checklist revealed Staff C's training topics included Medication Management and Nasal Spray Administration. 3. Record review on 5/11/26 of the program's policy Medication and Medication Administration-Iowa (effective/revised date 7/20/2022, rev. 4/1/23, 5/15/24, 7/2025) directed, "Staff performing medication duties are trained and monitored, according to the DIAL requirement of an approved medication management class" and "The Nurse will delegate medication administration to Resident Assistant" and noted medication administration was the aid's responsibility. During an interview on 5/18/26 at 1:30pm, the HCC was asked if staff allowing someone else (family/spouse/tenant) to administer medications to a tenant with a service plan identifying "staff to administer medications" followed the program's policy and/or training. The HCC confirmed doing so was against policy and training and staff were expected to "say no" if someone else asked or attempted to administer the medications.	A 200		

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A 201	481-67.9(4)g Staffing 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. This REQUIREMENT is not met as evidenced by: 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. This affected 1 of 1 discharged tenants (Tenant #C1). 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	A 201			

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A 201	Continued From page 71 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	A 201		

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A 201	Continued From page 72 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.	A 201			

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A 201	Continued From page 73 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.	A 201		
A 309	481-67.18(3)b Record Checks 481-67.18(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.18(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall complete the background check requirements set forth below. b. Conducting a background check. The program will either request that the department of public safety perform a criminal history check and that HHS perform child and dependent adult abuse record checks of the person in this state or access the single contact repository (SING) to perform the required background check. If SING is used, the program will submit the person's maiden name, if applicable, with the background check request.	A 309		

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A 309	Continued From page 74 This REQUIREMENT is not met as evidenced by: Based on record review and interview the Program failed to conduct background checks prior to hire. This affected 5 of 15 staff reviewed. Findings follow: Record review on 6/10/26 and 6/29/26 revealed the following: 1. A staff list provided by the Program identified Staff S's hire date as 12/15/25; however, further record review revealed a Counseling Documentation Form for Staff S, dated 12/12/25 documented on 12/10/25 Staff S worked a 10-6 and brought her child and significant other in to sleep in the community. The document was signed by Staff S 12/15/25. Continued review indicated Staff S's Single Contact License and Background Check (SING) completed on 12/15/25, after Staff S began employment with the Program. 2. A staff list provided by the Program and Staff Q's Personnel Action Notice indicated a hire date of 10/16/25. Continued review indicated Staff Q's SING completed on 4/13/26, after working several months for the Program . 3. A staff list provided by the program indicated Staff J's hire date of 7/24/25. Continued review indicated Staff J's last background check from Iowa Department of	A 309		

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NAME OF PROVIDER OR SUPPLIER LAWTON SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 200 E CHAR-MAC DR LAWTON, IA 51030		
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A 309	Continued From page 75 Human Services approved Staff J to work on 8/04/22. The Program failed to provide a current background check. 4. Staff B's Personnel Action Notice indicated a hire date of 9/16/25. Continued review indicated Staff B's SING completed on 1/17/26, after Staff B worked several months for the Program. 5. The Regional Nurse Specialist (RNS) transition letter indicated a hire date of 9/15/20. Continued review indicated the (RNS) SING completed on 5/06/26. 6. When interviewed on 7/16/26 at 2:14 p.m. the Regional Director of Operations confirmed the Program failed to complete the background checks.	A 309		
A 231	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation.	A 231		

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A 231	Continued From page 76 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete evaluations within 30-days of occupancy for 1 of 12 tenants reviewed (Tenant #6). Finding follows: Record review on 6/8/26 revealed Tenant #6 admitted to the program on 3/30/26 and resided in the program's memory care unit. A progress note dated 5/15/26 noted 30-day assessment completed with no changes. Continued review of the tenant's file revealed a 30-day evaluation completed on 5/14/26 by the Health Care Coordinator (HCC) and signed by all parties on 5/15/26. No additional evaluations were completed prior to 5/14/26. Record review on 6/9/26 revealed the program's policy, Assessment, Service Plan, dated 5/15/24 noted the comprehensive assessment including health, cognitive, and functional evaluations were completed prior to move in, within 30 days from move in, with status change, a return from the hospital, and annually every 365 days. During an interview on 6/10/26 at 4:05pm, the HCC confirmed she completed Tenant #6's 30-day assessment on 5/14/26 and acknowledged it was late.	A 231		
A 232	481-69.22(3) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(3) Evaluation annually and with	A 232		

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A 232	Continued From page 77 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. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the Program failed to complete evaluations following significant change in tenant condition. This pertained to 2 of 12 sample tenants reviewed (Tenant #9 and Tenant #C1). 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	A 232			

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A 232	Continued From page 78 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	A 232		

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A 232	Continued From page 79 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. 2. 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 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	A 232			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LAWTON SENIOR LIVING

**200 E CHAR-MAC DR
LAWTON, IA 51030**

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A 232	Continued From page 80 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	A 232		

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A 232	Continued From page 81 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	A 232			

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A 232	Continued From page 82 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	A 232			

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A 232	Continued From page 83 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	A 232		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

LAWTON SENIOR LIVING

**200 E CHAR-MAC DR
LAWTON, IA 51030**

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A 232	Continued From page 84 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	A 232		

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A 232	Continued From page 85 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	A 232			

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A 232	Continued From page 86 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.	A 232		
A 237	481-69.23(1)c(1-2) Criteria for Admission and Retention 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 This REQUIREMENT is not met as evidenced by: 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. This pertained to 1 of 1 sample tenant with inappropriate sexual behaviors (Tenant #9). Finding follows:	A 237		

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NAME OF PROVIDER OR SUPPLIER LAWTON SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 200 E CHAR-MAC DR LAWTON, IA 51030		
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A 237	Continued From page 87 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).	A 237		

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A 237	Continued From page 88 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	A 237		

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A 237	Continued From page 89 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 genital 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	A 237		

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A 237	Continued From page 90 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	A 237		

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A 237	Continued From page 91 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	A 237			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

LAWTON SENIOR LIVING

**200 E CHAR-MAC DR
LAWTON, IA 51030**

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A 237	Continued From page 92 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.	A 237		
A 241	481-69.23(g) Criteria for Admission and Retention 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: g. Has unmanageable incontinence on a routine basis despite an individualized toileting program; or This REQUIREMENT is not met as evidenced by:	A 241		

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A 241	Continued From page 93 Based on observation, interviews and record review, the program failed to ensure tenants met criteria for retention in the program due to unmanageable incontinence. This affected Tenants # 7, #8, and #10 and potentially affected all tenants in memory care due to odor of urine. Findings follow: 1. Observations on 4/9/26, 4/10/26, 4/11/26, 4/12/26, 5/17/26, 5/25/26, 7/24/26, and 7/25/26 revealed a strong smell of odor throughout the memory care unit and, at times, the area leading from the general population outside the door to memory care. The odor was particularly strong outside Tenants #7, # 8 and # 10 rooms. 2. When interviewed on 4/11/26, Staff B reported Tenant # 8 would sit on her couch and urine would leak from an unchanged brief. Tenant #8 didn't like to have her brief changed. On 4/17/26 the couch had been removed from Tenant #8's room. Record review on 7/28/26 revealed Tenant #8's service plan dated 6/24/26 directed staff to assist the tenant to the bathroom every 4 hours and assist with changing briefs. No additional interventions ere noted to assist Tenant #7 with continence or to address Tenant #8's refusals to be changed. 3. Observations on 6/9/26 at 10:15am revealed a strong odor emanating from Tenant #10's room. When asked about the smell, Staff M replied sarcastically, "What do you mean? That's the best smell in the world!" Further observation of Tenant #10's room revealed debris from incontinence briefs on the floor by the bed. When interviewed on 4/11/26, Staff B reported	A 241		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LAWTON SENIOR LIVING

**200 E CHAR-MAC DR
LAWTON, IA 51030**

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A 241	Continued From page 94 Tenant #10 refused to change his/her brief when it was wet and urine would leak onto the carpeted floor of his/her room. Record review on 7/28/26 revealed Tenant # 10's service plan, dated 3/19/26 revealed no mention of incontinence and no intervention for incontinence or refusing to change briefs. 4. Record review on 7/28/26 revealed Tenant #7's service plan dated 6/5/26 directed staff to assist Tenant #7 to the bathroom and change briefs if needed 8 times/day. The service plan also directed staff that after three attempts to change briefs, they should mark refused on the documentation. No other interventions were noted. When interviewed on 7/24/26 at approximately 6:40 p.m., Staff R reported Tenant #7 became violent when staff tried to change his briefs. When asked about interventions in place, she reported she thought staff were just supposed to have another staff try to assist with changing. She wasn't sure what other interventions are in place because she didn't have full access to tenant records. 5. When interviewed on 7/24/26 at 6:40 p.m., Staff DD reported Tenants #7, #8, and #10 did not like to change their briefs and urine leaked from their briefs onto the floor and furniture because they became so saturated. 6. Continued record review failed to reveal notice of involuntary transfer issued for Tenants #7, #8, or #10.	A 241		

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A 250	481-69.24(1)a Involuntary Transfer 481-69.24(231C) Involuntary transfer from the program. 69.24(1)Program initiation of transfer. The program shall comply with Iowa Code section 231C.6 and the following: a. The program will provide the tenant, or the tenant's legal representative, the contact information for the office of long-term care ombudsman. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide sufficient contact information for the long-term care ombudsman's office when issuing a 30-day notice of involuntary discharge for 1 of 2 former tenants reviewed (Tenant C2). Finding follows: Record review on 5/11/26 revealed Tenant C2 admitted to the program on 11/24/25. A progress note, dated 3/5/26, noted the program spoke with Tenant C2's brother "stating a 30-day (involuntary discharge) notice will be mailed today via certified mail." A progress note dated 3/13/26 noted "(Tenant C2) is currently on notice for above level of care in an AL/MC (Assisted Living/Memory Care)." Record review on 5/11/26 revealed a letter with a subject line "30-Day Discharge Notice Due to Exceeds Level of Care". The notice had a	A 250		

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A 250	Continued From page 96 handwritten notation at the bottom, which noted "certified mail 3/5/26". The notice indicated the brother/responsible party of Tenant C2 was the recipient of the involuntary discharge notice. The letter included: "This notice serves to inform you that you must vacate the premises by DISCHARGE DATE which is 30 days from the date of this notice" and "To initiate an appeal, you must contact the Office of the State Long-Term Care Ombudsman, 866-236-1430 within 30 days of receiving this notice." Review of the Occupancy Agreement (agreement version effective March 2025, page 12, Section E, item #2), dated and signed 2/17/26 by the Executive Director (ED) and Tenant C2's brother/responsible party, noted the procedure upon termination of the contract, and provided a different contact phone number for the long-term care ombudsman's office in comparison with the involuntary discharge notice: "If the community seeks to discharge the Resident based on the Discharge Criteria set forth in this agreement, and the Resident disagrees with the Community's decision, the Resident shall have the right to file a grievance and request a review of the discharge decision pursuant to 481 Iowa Administrative Code 69.24(1) and the Community's Internal Appeals Process, set forth in detail in the Policies and Procedures provided to Resident upon admission. A Resident or Resident's Representative who requires assistance may contact the Long-Term Care Ombudsman at 1-800-532-3213." The local Ombudsman replied via email on 5/12/26 at 11:53 pm after provided a copy of the involuntary discharge notice for review as	A 250		

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A 250	Continued From page 97 provided to Tenant C2's family representative. The local Ombudsman indicated she did not receive notice of involuntary discharge from the program for Tenant C2. She further indicated the wording of the notice didn't appear to be correct or descriptive enough, as there is no address for the Long-Term Care Ombudsman's (LTCO) office nor much information on guidance through the process. The Ombudsman indicated she visited the program on 4/22/26, but the program did not make any mention of an involuntary discharge notice previously sent. During an interview on 5/11/26 at 4:00pm with the Health Care Coordinator (HCC) stated she was unaware of the process for involuntary discharge. She indicated the former Executive Director prepared the notice of involuntary discharge for Tenant C2.	A 250		
A 251	481-69.24(1)b Involuntary Transfer 481-69.24(231C) Involuntary transfer from the program. 69.24(1)Program initiation of transfer. The program shall comply with Iowa Code section 231C.6 and the following: b. The program will immediately provide to the office of long-term care ombudsman, by mail or email, a copy of the notification and notify the tenant's treating physician, if any. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	A 251		

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A 251	Continued From page 98 program failed to provide a copy of notice of involuntary discharge to the office of the long-term care ombudsman and the tenant 's treating physician for 1 of 2 discharged tenants reviewed (Tenant C2). Finding follows: Record review on 5/11/26 revealed Tenant C2 admitted to the program on 11/24/25. A progress note, dated 3/5/26, documented the program spoke with Tenant C2's brother "stating a 30-day (involuntary discharge) notice will be mailed today via certified mail." A progress note, dated 3/13/26, documented "(Tenant C2) is currently on notice for above level of care in an AL/MC (Assisted Living/Memory Care)." Review of a letter with subject line "30-Day Discharge Notice Due to Exceeds Level of Care" with a handwritten notation at the bottom,"certified mail 3/5/26", noted the brother/responsible party of Tenant C2 was the recipient of the involuntary discharge notice. The letter included : "This notice serves to inform you that you must vacate the premises by DISCHARGE DATE which is 30 days from the date of this notice" and "To initiate an appeal, you must contact the Office of the State Long-Term Care Ombudsman, 866-236-1430 within 30 days of receiving this notice." Review of an Occupancy Agreement (agreement version effective March 2025, page 12, Section E, item #2), dated and signed 2/17/26 by the Executive Director (ED) and Tenant C2's brother/responsible party noted the following as part of the procedure upon termination of the contract:	A 251		

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NAME OF PROVIDER OR SUPPLIER LAWTON SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 200 E CHAR-MAC DR LAWTON, IA 51030		
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A 251	Continued From page 99 "The community send discharge notices via certified mail to Resident/Responsible Party. Discharge notice will be a part of the resident file and provided to the Long-Term Care Ombudsman at 510 E. 12th Street, Rm 2, Des Moines, Iowa 50319. The Resident's treating physician, if applicable will also be notified of the discharge notice." The local Ombudsman replied via email on 5/12/26 at 11:53 pm after provided a copy of the involuntary discharge notice for review as provided to Tenant C2's family representative. The email noted she did not receive notice of involuntary discharge from the program. The Ombudsman indicated she visited the program on 4/22/26, but the program did not make mention of an involuntary discharge notice previously sent. Record review on 6/15/26 revealed a letter from Tenant C2's primary care physician confirmed she had not been notified of an involuntary discharge for Tenant C2. When interviewed on 5/11/26 at 4:00pm the Health Care Coordinator (HCC) indicated she was unaware of the process for involuntary discharge. She indicated the notice of involuntary discharge for Tenant #C2 was prepared by the former Executive Director.	A 251			
A 252	481-69.24(1)c Involuntary Transfer 481-69.24(231C) Involuntary transfer from the program. 69.24(1)Program initiation of transfer. The	A 252			

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/05/2026
NAME OF PROVIDER OR SUPPLIER LAWTON SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 200 E CHAR-MAC DR LAWTON, IA 51030		
(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 252	Continued From page 100 program shall comply with Iowa Code section 231C.6 and the following: c. Pursuant to statute, the office of long-term care ombudsman will offer the notified tenant or tenant's legal representative assistance with the program's internal appeal process. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to notify the office of the long-term care ombudsman of a tenant's involuntary notice of discharge, preventing the long-term care ombudsman to offer assistance to the notified tenant or tenant's legal representative with the program's internal appeal process for 1 of 2 discharged tenants reviewed. (Tenant #C2). Finding follows: Record review on 5/11/26 revealed Tenant C2 admitted to the program on 11/24/25. A progress note, dated 3/5/26, documented the program spoke with Tenant C2's brother "stating a 30-day (involuntary discharge) notice will be mailed today via certified mail." A progress note, dated 3/13/26, documented "(Tenant C2) is currently on notice for above level of care in an AL/MC (Assisted Living/Memory Care)." Review of a letter with subject line "30-Day Discharge Notice Due to Exceeds Level of Care" with a handwritten notation at the bottom, "certified mail 3/5/26", noted the brother/responsible party of Tenant C2 was the recipient of the involuntary discharge notice. The letter included : "This notice serves to inform you that you must vacate the premises by DISCHARGE DATE	A 252			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/05/2026
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

LAWTON SENIOR LIVING **200 E CHAR-MAC DR**
LAWTON, IA 51030

(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 252	Continued From page 101 which is 30 days from the date of this notice" and "To initiate an appeal, you must contact the Office of the State Long-Term Care Ombudsman, 866-236-1430 within 30 days of receiving this notice." Review of an Occupancy Agreement (agreement version effective March 2025, page 12, Section E, item #2), dated and signed 2/17/26 by the Executive Director (ED) and Tenant C2's brother/responsible party noted the following as part of the procedure upon termination of the contract: "The community send discharge notices via certified mail to Resident/Responsible Party. Discharge notice will be a part of the resident file and provided to the Long-Term Care Ombudsman at 510 E. 12th Street, Rm 2, Des Moines, Iowa 50319. The Resident's treating physician, if applicable will also be notified of the discharge notice." When asked and provided a copy of the involuntary discharge notice for review as provided to Tenant #C2's family representative, the local Ombudsman replied via email on 5/12/26 at 11:53pm she never received any notice of involuntary discharge from the program. The Ombudsman noted she visited the program on 4/22/26, but the program "did not make any mention of an INVD (involuntary discharge notice) that was previously sent out." During an interview on 5/11/26 at 4:00pm the Health Care Coordinator (HCC), reported she was unaware of the process for involuntary discharge. She indicated the notice of involuntary discharge for Tenant #C2 was prepared by the former Executive Director.	A 252		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/05/2026
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A 259	69.25(1) Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the Program failed to ensure documentation for each tenant was adequately completed and maintained. Findings follow: 1. When interviewed on 5/6/26 at 5:49 a.m. Staff R reported Staff P should not chart because it (Yardi) had not been made available to her. Staff O further commented no one had explained charting to her and she was not sure if she had completed it correctly. When interviewed on 5/27/26 at 5:44 a.m. Staff R stated she and other agency staff had no idea where care plans were. They did not receive any training on Yardi (electronic health record system), and some staff did not have login information. Staff R reported when she first began working at the Program she was unable to char on residents as the nurse. When she completed an assessment on Tenant #5 the Health Care Coordinator (HCC) told her she was told to call triage, but the triage nurse did not know about the tenant. Because she could not access Yardi, she documented the assessment on paper and gave it to the HCC. When interviewed on 6/25/26 at 11:10 a.m. Staff V reported he did not recive a username and	A 259		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/05/2026
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A 259	Continued From page 103 password to be able to document in the tenant record. Staff V further noted he was unable to access tenant service plans without a username and password. When interviewed on 6/12/26 at 9:03 a.m. the Resident Services Coordinator (RSC) acknowledged not all staff had access to Yardi. He stated he let the HCC know when staff needed access, but he did not have the ability to create users. He stated staff would chart under other staff if they completed documentation. He confirmed staff frequently did not document in the tenant record. 2. See IAC 481-69.25(1)i, IAC 481-69.25(1)q, and IAC 481-69.25(1)o for additional failures regarding maintaining tenant documentation.	A 259		
A 268	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to maintain documentation of	A 268		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/05/2026
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A 268	Continued From page 104 tenant physician medication orders for 1 of 2 discharged tenants reviewed (Tenant #C2). Findings follow: 1. Record review on 5/18/26 revealed Tenant #C2 admitted to the program on 11/24/25. The initial set of physician orders for Tenant #C2's medications on file with the program were dated 12/10/25. The Regional Nurse Specialist confirmed via email on 5/21/26 that she was unable to locate any orders from the date of admission until the 12/10/25 date for Tenant #C2. 2. Record review on 5/19/26 revealed Tenant #C2's March 2026 Medication Administration Record (MAR) indicated Ativan 0.25mg should be given by mouth three times per day every day at 10:00am, 1:00pm, and 4:00pm. The Regional Nurse Specialist confirmed via email on 5/29/26 the Program had no physician's order for Ativan 0.25mg order on file. 3. Record review of 6/17/26 revealed Tenant #C2's primary care physician (PCP) provided a medication order, dated 3/5/26, adjusting Tenant C2's lorazepam and noted please give the Lorazepam 0.5mg tablet to this patient every 8 hours - on a schedule until he was seen at the office on 3/9/26. This was the recommendation of the Emergency Room (ER) doctor today at Unity Point St. Lukes - South campus/ER. The Program was unable to provide the 3/05/26 PCP order after several requests. When interviewed on 7/16/26 at 2:02 p.m. the Regional Nurse Specialist (RN) indicated she was	A 268			

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A 268	Continued From page 105 not able to answer questions overseeing the Program at Lawton Senior Living. She indicated the Health Care Coordinator was in charge since the delegation changes in Assisted Living.	A 268		
A 274	481-69.25(1)o Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports need not be included in the tenant's medical record); This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the Program failed to ensure and maintain documentation of tenant accidents and falls. This pertained to 1 of 2 former tenants reviewed (Tenant #C1). Finding follows: See Iowa Administrative Code (IAC) 481-67.2(2) and IAC 481-67.3(2) for additional information regarding this incident. 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	A 274		

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A 274	Continued From page 106 Resident Aide indicated the tenant may have had an unwitnessed fall on a previous shift. During an interview on 06/26/26 at 8:15 a.m., Staff G 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. Continued record review confirmed an incident report had not been completed for Tenant #C1's fall alleged to have occurred 4/3/26.	A 274		
A 276	481-69.25(1)q Tenant Document 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple	A 276		

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A 276	Continued From page 107 service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks will be part of the medication administration records (MARs); This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide accurate documentation regarding wanderguard bracelet/fob placement and function for 1 of 1 tenants reviewed (Tenant #7). Findings follow: 1. Record review on 6/18/26 and 6/22/26 revealed: a. Tenant #7 admitted to the program 7/13/23. b. Review of a quarterly nurse review dated 3/15/26 noted Tenant #7 wore a wanderguard bracelet on his ankle at all times due to cognitive impairment and previous efforts to leave the building. A review of Tenant #7's March 2026 Monthly Task Log identified Tenant #7 utilized a wander bracelet/fob and instructed program staff to check the placement and function every shift and the log showed this task was documented as completed each shift. Review of Tenant #7's progress notes dated 4/17/26 noted the program applied a wanderguard bracelet after Tenant #7 attempted to elope from the program two times on 4/16/26. After the wanderguard was applied on 4/16/26, the progress notes further noted Tenant #7 then broke off his wanderguard on 4/17/26.	A 276		

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A 276	Continued From page 108 c. A review of the Monthly Task log documentation from April 2026 noted program staff continued to document Tenant #7's wander bracelet/fob was in place and functioning each shift, with the exception of the following dates/times/notations: *04/18/2026 2:28PM OTH: Resident took it off. *04/19/2026 2:48PM CA: Resident using walker, did not utilize fob *04/19/2026 4:39PM CA: Utilizes walker, does not utilize fob *04/22/2026 1:16PM OTH: Does not have it on anymore *04/25/2026 11:12AM OTH: Does not have a wander guard *04/26/2026 8:39AM OTH: Doesn't have one *04/26/2026 9:49PM AC: Completed *04/27/2026 1:11PM OTH: Does not have one *04/29/2026 10:01AM OTH: Doesn't have a wander fob *04/30/2026 12:05PM OTH: Does not have one A review of the Monthly Task log documentation from May 2026 noted program staff continued to document Tenant #7's wander bracelet/fob was in place and functioning each shift, with the exception of the following dates/times/notations: *05/10/2026 10:57AM OTH: Doesn't have one *05/13/2026 6:30AM OTH: Does not have one *05/15/2026 5:30PM OTH: He does not have one *05/15/2026 12:18PM OTH: Does not have one *05/16/2026 1:37PM OTH: Doesn't have one *05/17/2026 9:01PM OTH: He does not have one *05/17/2026 11:09AM OTH: Doesn't have one *05/19/2026 2:11PM OTH: Doesn't have one *05/20/2026 6:40AM OTH: He doesn't have one *05/21/2026 3:36PM OTH: Doesn't have one *05/21/2026 8:30AM OTH: Doesn't have one *05/22/2026 2:11PM OTH: Doesn't have one yet *05/22/2026 7:26AM OTH: Doesn't have one yet	A 276		

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A 276	Continued From page 109 *05/26/2026 12:56PM OTH: Doesn't have a wander fob *05/28/2026 3:42PM OTH: Doesn't have one yet *05/28/2026 8:00AM OTH: Doesn't have one yet *05/30/2026 2:00PM OTH: Does not have one *05/31/2026 3:06PM OTH: Does not have one On 7/28/26 at 8:16am, the Regional Director of Operations (RDO) replied via email and acknowledged Tenant #4's service plan identified the need for the tenant to utilize a wanderguard bracelet/fob. 2. Record review on 5/12/26, 6/1/26, and 6/2/26 revealed: Tenant #4 admitted to the program on 5/3/26. Tenant #4's 4/21/26 pre-admission service plan noted under the Emergency Response section of the service plan Tenant #4 utilized a wander bracelet/fob and instructed staff to check placement and function every shift. Under the Psychosocial section of the service plan, it noted Tenant #4 had no wandering issues and did not have a current or history of wandering. A review on 6/2/26 of Tenant's #4's May 2026 Monthly Task log did not appear to have been created until 5/14/26. Dates of 5/3/26 (when Tenant #4 reportedly admitted to the program) to 5/13/26 were blacked out. All tasks created on the Monthly Task log revealed a creation date/time of 5/14/26 at 7:27am. The bottom on page 2 of the May Monthly Task Log noted Tenant #4 utilized a wander bracelet/fob and instructed staff to check placement and function every shift. The task log noted some program staff as documenting these checks were complete, while others noted the following: *05/19/2026 1:34PM OTH: Resident doesn't have	A 276		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/05/2026
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A 276	Continued From page 110 one yet *05/21/2026 3:45PM OTH: Doesn't have one yet *05/21/2026 8:35AM OTH: Doesn't have one *05/22/2026 5:09PM OTH: Doesn't have one yet *05/22/2026 9:32AM OTH: Doesn't have one yet *05/24/2026 12:55PM OTH: Does not have one *05/26/2026 12:55PM OTH: Doesn't have one *05/28/2026 3:50PM OTH: Doesn't have one yet *05/28/2026 8:02AM OTH: Doesn't have one yet *05/31/2026 3:00PM OTH: Does not have one A review on 6/1/26 of Tenant #4's June 2026 Monthly Task Log noted Tenant #4 utilized a bracelet/fob and instructed program staff to check placement and function every shift, but noted the following for the date of 6/1/26: *06/01/2026 7:46am OTH: Does not have one On 7/28/26 at 8:16am, the Regional Director of Operations replied via email and acknowledged the monthly task logs related to concerns with wanderguard documentation and stated Tenant #7 was very skilled in removing his wanderguard as soon as one was place. The RDO stated she was uncertain why monthly task sheets were not populating correctly and stated they had a service ticket in for the issue.	A 276		
A 282	481-69.26(3) Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. The service plan shall be	A 282		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LAWTON SENIOR LIVING

**200 E CHAR-MAC DR
LAWTON, IA 51030**

(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 282	Continued From page 111 signed by all parties, including the tenant or tenant's legal representative. This REQUIREMENT is not met as evidenced by: 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. This pertained to 3 of 10 tenants reviewed (Tenant #1, Tenant #5, and Tenant #9). 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	A 282		

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NAME OF PROVIDER OR SUPPLIER LAWTON SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 200 E CHAR-MAC DR LAWTON, IA 51030		
(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 282	Continued From page 112 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.	A 282		

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A 282	Continued From page 113 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. 2. Record review on 5/4/26 revealed Tenant #1 admitted to the program on 2/7/25. The program provided an annual service plan for Tenant #1 completed 3/4/26. The provided service plan was unsigned by all parties. The Regional Director of Operations confirmed via email on 6/9/26 a signed service plan for Tenant #1's 30-day service plan could not be located. 3. Record review on 5/27/26 revealed Tenant #5 admitted to the program on 2/13/26. The program provided a 30-day service plan for Tenant #5, showing assessment date 3/15/26 and effective date 3/18/26. The provided service plan was unsigned by all parties. The Regional Director of Operations confirmed via email on 6/16/26 no signed service plan for Tenant #5's 30-day service plan could be located.	A 282		
A 285	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and indicate:	A 285		

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LAWTON SENIOR LIVING **200 E CHAR-MAC DR**
LAWTON, IA 51030

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A 285	Continued From page 114 a. The tenant's identified needs and preferences for assistance; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the program failed to ensure service plans were individualized and accurately addressed needs for 1 of 2 tenants reviewed who used a Wanderguard (Tenant #4). Finding follows: Observations on 6/1/26 at 1:36pm revealed Tenant #4 walking the path around the program unattended by staff. Further observations on 6/1/26 at 1:41pm noted Tenant #4 walking the path around the program unattended by staff. At 2:38pm Tenant #4 walked the path around the program with Staff K. Record review on 6/1/26 revealed Tenant #4's 4/21/26 pre-admission service plan (current service plan at the time of observations) noted Tenant #4 utilized a wander bracelet/fob and instructed staff to check placement and function every shift. However, the Psychosocial section of the service plan, noted Tenant #4 had no wandering issues and did not have a current or history of wandering. Additional record review on 6/1/26 revealed Tenant #4's June Monthly Task Log noted the use of a wanderguard bracelet/fob and instructed staff to check placement and function every shift. On 6/1/26 Staff M documented Tenant #4 "does not have one." Continued record review on 6/2/26 revealed	A 285		

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A 285	Continued From page 115 Tenant #4's May 2026 Monthly Task log did not appear to have been created until 5/14/26. Dates of 5/3/26 (when Tenant #4 reportedly admitted to the program) to 5/13/26 were blacked out. All tasks created on the Monthly Task log noted a creation date/time of 5/14/26 at 7:27am. The task log noted Tenant #4 utilized a wander bracelet/fob and instructed staff to check placement and function every shift. Further review of the task log revealed some program staff documented checks as complete, while others noted the following: *05/19/2026 1:34PM OTH: Resident doesn't have one yet *05/21/2026 3:45PM OTH: Doesn't have one yet *05/21/2026 8:35AM OTH: Doesn't have one *05/22/2026 5:09PM OTH: Doesn't have one yet *05/22/2026 9:32AM OTH: Doesn't have one yet *05/24/2026 12:55PM OTH: Does not have one *05/26/2026 12:55PM OTH: Doesn't have one *05/28/2026 3:50PM OTH: Doesn't have one yet *05/28/2026 8:02AM OTH: Doesn't have one yet *05/31/2026 3:00PM OTH: Does not have one Additional record review on 6/3/26 revealed Tenant #4's comprehensive 30-day assessment dated 6/3/26 indicated Tenant #4 did not have a current or history of wandering. When interviewed on 6/3/26 at 3:37pm, Staff C stated she had been instructed Tenant #4 was always to have someone walk with her outside. Staff C reported she was told Tenant #4 was supposed to have a wander bracelet, but Staff C hadn't seen one yet. Staff C stated she regularly charted Tenant #4 did not have a wanderguard in place. Record review on 6/4/26 revealed Tenant #4's Progress Notes included the following:	A 285		

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A 285	Continued From page 116 a. On 5/18/26 at 2:15pm, the Health Care Coordinator (HCC) noted Tenant #4 was to have staff when walking outside, per a new order from Tenant #4's provider Curana. b. On 6/1/26 at 3:00pm, but noted for an effective date of 5/4/26 at 3:00pm, the HCC documented Tenant #4 took her wanderguard off and would not let staff apply it again. c. On 6/2/26 at 8:53am the 400 Hall alarm went off, staff found Tenant #4's wanderguard in a kitchen drawer. Tenant #4 was asked to put it on and refused. d. On 6/2/26 at 11:18am the HCC noted the wanderguard bracelet was removed from Tenant #4's service plan due to Tenant #4 not keeping it on and refusing to put it back on. Continued record review on 6/4/26 revealed Tenant #4's May 2026 Medication Administration Record (MAR) noted when Tenant #4 walked outside, she must have a staff escort, with a 5/18/26 start date. The order was on the MAR three times per day, every day at 8:00am, 12:00pm, and 4:00pm. Review on 6/17/26 revealed the order from the Curana provider, dated 5/18/26, for Tenant #4 to have staff when walking outside. The order did not specify the times this was to occur. On 7/28/26 at 8:16am, the Regional Director of Operations (RDO) replied via email and acknowledged Tenant #4's service plan identified the need for the tenant to utilize a wanderguard bracelet/fob. The RDO was not able to provide a reason why Tenant #4 had been observed outside without staff.	A 285		

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LAWTON SENIOR LIVING

**200 E CHAR-MAC DR
LAWTON, IA 51030**

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A 287	481-69.26(4)c Service Plans 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; This REQUIREMENT is not met as evidenced by: 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	A 287		

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A 287	Continued From page 118 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.	A 287		
A 293	481-69.27(2)c Nurse Review 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	A 293		

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A 293	Continued From page 119 every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: 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. This pertained to 1 of 2 former tenants reviewed (Tenant #C1). 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 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. 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 extremities. (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	A 293		

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A 293	Continued From page 120 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	A 293		

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A 293	Continued From page 121 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. Upon arrival patient in her room... Bruising reported 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	A 293		

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A 293	Continued From page 122 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	A 293		

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A 293	Continued From page 123 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	A 293			

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NAME OF PROVIDER OR SUPPLIER LAWTON SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 200 E CHAR-MAC DR LAWTON, IA 51030
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 293	Continued From page 124 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	A 293		

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A 293	Continued From page 125 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.	A 293		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

LAWTON SENIOR LIVING **200 E CHAR-MAC DR**
LAWTON, IA 51030

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A 293	Continued From page 126 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	A 293		

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A 293	Continued From page 127 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.	A 293		

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A 293	Continued From page 128 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	A 293		

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A 293	Continued From page 129 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	A 293		

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A 293	Continued From page 130 experienced a change in condition.	A 293		
A 322	481-69.29(3) Staffing 481-69.29(231C) Staffing. In addition to the general staffing requirements in rule 481-67.9(231B,231C,231D), the following requirements apply to staffing in programs. 69.29(3) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and the target population. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the Program failed to ensure employees received appropriate training to complete assigned tasks and adequately assist tenants. This affected 4 of 4 tenants reviewed for medication administration (Tenant #C1, Tenant #C2, Tenant #1, and Tenant #3) and potentially affected 28 of 28 tenants residing at the Program. Findings follow: 1. Record review on 6/11/26 revealed Staff G, a 16 year-old universal worker, was hired 11/30/25. See Iowa Administrative Code 481 Chapter 67.3(2) for additional information. Review of Staff G's training documentation included a checklist with tasks including, but not limited to: ambulation with walker, assistive	A 322		

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LAWTON SENIOR LIVING

**200 E CHAR-MAC DR
LAWTON, IA 51030**

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A 322	Continued From page 131 devices, change of condition, communication, resident rights, infection control, safety of resident, fall prevention and reduction, grooming, incident report and communication, incontinence care, restraints, showers, skin care, toileting assistance, transferring a resident, using a gait belt for ambulation, and visual checks. Staff G initialed, signed, and dated each task on 12/22/25. The documentation failed to include nurse initials or signature indicating training completed. When interviewed on 6/26/26 at 8:06 a.m. Staff G stated he completed all training on the computer, and completed no hands on training. He worked with another staff member, but never worked with a nurse on skills. Staff G stated he received no training on fall response or emergency situations. He further stated he received no specific training on tenants or their service plans. 2. Record review on 5/20/26, 5/21/26, and 5/26/26 for Medication Administration Records revealed Staff G, Staff H, and Staff I administered medications prior to and/or without having completed a department-approved medication manager course. See Iowa Administrative Code 481 Chapter 67.5(2)e(1) for additional information. a. Record review of tenant medication administration records (MARs) revealed Staff G, 16 years old, administered medications to tenants on at least the following dates: 2/13/26 and 3/28/26 to Tenant #C2, Tenant #3, Tenant #1, and Tenant #C1.	A 322		

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A 322	Continued From page 132 Continued record review revealed Staff G was hired on 12/4/25 and terminated on 4/6/26. The program failed to provide a certificate of completion for Staff G of an approved medication manager course. Additional record review revealed skills delegations for Staff G initialed, signed, and dated by him on 12/22/25. The documentation failed to include nurse initials or signature indicating training completed. Further review of delegations failed to reveal training completed regarding medication administration. When interviewed on 5/11/26 at 3:18 p.m. the Health Care Coordinator (HCC) confirmed Staff G was not medication delegated or old enough to pass medication. b. Record review revealed Staff H administered medications to tenants on at least the following dates: 2/12/26, 3/11/26, 3/12/26, and 4/25/26 to Tenant #C2, Tenant #3, and Tenant #1. Continued record review failed to provide documentation of Staff H's completion of an approved medication manager course. Additionally, documentation was not provided to indicate completion of training regarding medication administration. When interviewed on 5/20/26 at 3:05 p.m. the HCC confirmed Staff H was not trained on medication administration. c. Record review revealed Staff H administered medications to tenants on at least 3/3/26. Continued record review failed to provide documentation of Staff I's completion of an	A 322		

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A 322	Continued From page 133 approved medication manager course. Additionally, documentation was not provided to indicate completion of training regarding medication administration. During a staff interview on 5/20/26 at 3:05pm the HCC and RSC were unaware Staff I documented as having administered any medications. The RSC confirmed Staff I was not trained as she was not old enough to take the medication manager course. 3. When interviewed on 6/25/26 at 11:10 a.m. Staff V reported he was assigned Tenant #C1 on 4/3/26. Staff V began employment at Holstein Senior Living, but had worked at Lawton Senior Living for a month due to staffing issues. Staff V reported he typically worked in the assisted living side of the Program, but was moved to the memory care unit for his second shift on 4/3/26. He reported Staff G, a 16 year-old universal worker, was asked to train him in the memory care unit. Staff G reportedly told Staff V he did not like to train people and did not like people. Staff G told Staff V to go back to the assisted living side, so he left. Record review revealed skills delegations provided for Staff V noted they were for Holstein Senior Living. Staff V initialed and dated 12/18/25. When interviewed on 6/12/26 at 9:03 a.m. the Resident Services Coordinator explained staff would train new staff on tenant plans.	A 322			
A 385	481-69.35(1) Activities 481-69.34(231C) Activities. The program shall	A 385			

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A 385	Continued From page 134 have a policy related to activities, including the following: 69.34(1) The program will provide appropriate activities for each tenant reflecting individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skills by providing opportunities for a variety of types and levels of involvement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the program failed to consistently provide opportunities for appropriate activities, for 10 of 10 tenants reviewed and/or with the potential to affect all tenants residing at the program. Findings follow: 1. Observations on 5/4/26 at 2:05pm revealed a daily activity breakout display board reflected daily breakout of activities from April 20th to April 26th. The large monthly activity calendar board located outside the activity room was posted for the month of April, not May. When interviewed during this time, the Regional Operations Specialist indicated the program's Life Engagement Coordinator (Staff J) was recently terminated. The Regional Operations Specialist reported the program was currently providing activities, by currently staffing enough direct care staff, along with management present filling in for activities. Review review on 5/4/26 of the program's terminated employee list revealed Staff J	A 385			

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LAWTON SENIOR LIVING

**200 E CHAR-MAC DR
LAWTON, IA 51030**

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A 385	Continued From page 135 terminated on 4/29/26. 2. Observations on 5/5/26 at 8:00am revealed the large monthly activity calendar posted outside the activity room reflected the month of May. At 11:04 am, no morning activities had yet been provided as of this time. At 12:30pm, Agency Staff (Staff L) suggested puzzles or cards to memory care tenants. Staff L selected some activity items from the centralized area in the hallway, returned and began engagement with memory care tenants. 3. Observations on 5/14/26 at 9:10 am, revealed the monthly activity calendar noted the following activities to occur during the afternoon: 12:00 pm - Country Music Hour, 2:00 pm - Coffee Social, and 3:30 pm - Bingo. When interviewed on 5/14/26 at 9:15am, the Health Care Coordinator (HCC) indicated her PRN (as needed) Activities staff (Staff K) would be coming in to provide activities. Continued observations revealed at 12:15pm, no County Music Hour observed and at 2:15pm, no Coffee Social observed. 3. Observations on 5/18/26 at 2:30pm revealed the posted monthly activity calendar noted Bingo at this time. At 2:50pm, no Bingo observed being provided 4. Observations on 5/19/26 at 11:15am revealed the activity room, living room, and dining room area had no Chair Yoga/Exercise provided as posted on the monthly calendar. At 1:15pm, the activity room, living room, and dining room area had no Resident's Meeting provided as posted on the monthly calendar. At 3:09pm, the activity room, living room, and dining room area had no	A 385		

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NAME OF PROVIDER OR SUPPLIER LAWTON SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 200 E CHAR-MAC DR LAWTON, IA 51030		
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A 385	Continued From page 136 Games activity provided as posted on the monthly calendar. At 3:55pm, the activity room, living room, and dining room area had no Community Spotlight activity provided as posted on the monthly calendar. 5. Observations on 5/20/26 at 11:30am revealed the activity room, living room, and dining room area had no Chair Yoga/Exercise provided as posted on the monthly calendar. At 1:20pm, the activity room, living room, and dining room area had no Nail Care activity provided as posted on the monthly calendar. At 1:30pm, the activity room, living room, and dining room area had no Card Tournament provided as posted on the monthly calendar. 6. Observations on 5/21/26 at 11:15am revealed the activity room, living room and dining room area had no Chair Yoga/Walk Around the Building activity provided as posted on the monthly calendar. At 12:52pm: the activity room and living room had no Learning Hour activity held as posted on the monthly calendar. Tenants were observed beginning to gather in the dining room area. When interviewed, Staff C indicated they were getting ready to have a Resident Meeting (as posted on the monthly calendar two days prior on 5/19/26) and Staff C believed someone was then going to provide Bingo after the meeting. 7. Record review on 5/19/26 revealed the program's Activities Program policy noted opportunities were provided for activities of daily living, socialization, physical activities, education, and leisure. 8. When interviewed on 5/21/26 at 1:55pm Staff K indicated she attempted to work half days three times per week providing activities, but she had to	A 385			

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A 385	Continued From page 137 cancel one of her half days this week and would only work two half days next week as well. 9. During an interview on 6/11/26 at 11:20am, Tenant #1 indicated she was glad a new activity director was recently hired, but it had been a while. Tenant #1 missed the old activity director as she was there every day, she kept them active, and they had good times. She indicated the old activity director was always asking them to come do things. When asked if program staff had been providing activities during the interim, she reported there wasn't anything really to come out for, but acknowledged Staff K continued to at least provide Bingo. 10. A review on 6/11/26 of the last three months of tenant meeting notes revealed the April 2026 tenant meeting notes identified they wanted more under activities.	A 385		
A 391	481-69.35(1)b Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. b. The buildings and grounds will be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the Program failed to ensure a clean, sanitary, and well-maintained environment. This potentially affected all tenants residing at the Program.	A 391		

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A 391	Continued From page 138 Findings follow: 1. Observations on 5/23/26 at 1:30pm revealed a carafe of drinking water for tenants, located in the lobby. Upon further inspection, the water appeared very cloudy. Brown cucumbers floated on top, along with foam that had formed. When asked if the water was for tenants, Staff reported it was. When asked why it was so cloudy, she stated, "Yeah, I don't think it's been changed in a few days." The surveyor requested the staff remove the carafe from the area. Staff responded that dietary staff would arrive soon and could do it. When interviewed on 5/23/26 at 2:30pm, the Regional Director of Operations confirmed the water provided in the carafe was unacceptable. 2. Observations on 4/10/26 at 2:30pm revealed a strong, foul odor near the dining room area of the memory care unit. At 3:15pm the surveyor asked the Health Care Coordinator (HCC) to walk down the memory care unit hallway to find the foul odor. As they approached the dining room, the HCC stated, "It's probably the cat litter box." Upon reaching the dining room, which tenants also used for activities, and they approached a cat litter box, the odor became overwhelming. Observations on 4/11/26 at 11:00am revealed a urine smell in the memory care unit, though the cat litter box had been removed. When interviewed on 4/11/26 at 11:00am Staff reported the cat litter box had not been cleaned for several weeks. Staff B also reported the smell likely stemmed from two tenants residing on the memory care unit who displayed unmanageable incontinence and would urinate on their furniture.	A 391		

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A 391	Continued From page 139 3. Observations on 4/9/26 at 1:40pm revealed a strong smell of urine in the hallway. When interviewed on 4/11/26 at 11:00am Staff reported the cat litter box had not been cleaned for several weeks. Staff B also reported the smell likely stemmed from two tenants residing on the memory care unit who displayed unmanageable incontinence and would urinate on their furniture. Observations on 4/12/26 at 3:00pm revealed continuing odor of urine in the memory care unit and just outside of the memory care unit in the assisted living unit. The HCC stated they would take care of it. She believed it stemmed from a room in the assisted living unit, just outside of the memory care unit and two rooms in the memory care unit. Observations on 5/5/26 from 4:20pm - 4:50pm revealed an obvious odor at the end of the hallway. The odor appeared to emanate from Tenant #5's room. Observations on 5/06/26 at 6:37 a.m. revealed a strong smell of urine from Tenant #9's room. Staff L indicated there were three soiled briefs found in his room. At 6:39 a.m., Tenant #9's bathroom has dark orange and yellow stains on the floor. Staff O indicated she needed to clean the room because it smelled yesterday (5/05/26). Observations on 5/17/26 at 5:00pm revealed a urine odor within the memory care unit and in the assisted living unit, just outside the memory care unit. Observations on 6/9/26 at 10:15am revealed a	A 391		

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A 391	Continued From page 140 strong odor emanating from Tenant #10's room. When asked about the smell, Staff M replied sarcastically, "What do you mean? That's the best smell in the world!" Further observation of Tenant #10's room revealed debris from incontinence briefs on the floor by the bed. Observations on 7/24/26 at 6:40 p.m. revealed the memory care unit smelled strongly of urine, including outside of the door to the unit. Staff reported Tenant #7, Tenant #8, and Tenant #10 do not like to have their incontinence briefs changed and urine leaked onto the floor as a result. Staff reported Tenant #8's couch had been removed, but had previously been soaked with urine. Observations on 7/25/26 at 2:52 p.m. revealed a strong odor of urine throughout the memory care unit and outside the door to the unit. Observations on 7/26/26 at 12:05 p.m. revealed Staff B and Staff EE shampooed carpets and ran a fan in the hallway to assist with drying. They found several wall plug-ins for odors, as well as an air purifier with scent to use on the unit. 4. Observations on 6/21/26 at 3:30p.m. revealed Staff X leaned on the counter for several minutes on her cell phone before she laid her phone on the counter and served desserts to tenants without washing her hands. When interviewed on 6/21/26 the Regional Operations Specialist acknowledged this was not appropriate.	A 391		