DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0078	A. BUILDING: _____ B. WING _____	C 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER RIDGE PLACE	205 EHLERS LANE MAQUOKETA, IA 52060

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A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 28 Number of tenants with cognitive impairment: 17 Total census: 45 The following regulatory insufficiencies were cited related to the investigation of Complaints #1299912-C and #130006-C. There were no regulatory insufficiencies cited related to Complaint #130162-C:	A 000	See attached POC 10/14/25	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to follow established food policy and procedure. This potentially affected all tenants (census of 45). Findings follow: 1. Observation on 9/9/25 at 11:35 a.m. during the lunch meal service revealed Staff E plated food from the pans to plates. The meal served as shrimp fettuccine Alfredo, broccoli , garlic breadstick and Tiramisu. Staff E used utensils to dish up the shrimp fettuccine Alfredo and broccoli	A 150		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 150	Continued From page 1 and had gloves on. He used utensils to dish up the food and removed the lids to pans as each plate was prepared. It was observed he picked up the garlic breadsticks and placed them on plates with a gloved hand without a utensil. The gloved hand was contaminated as he had touched other surfaces, including utensils and pan lids frequently throughout the meal service, without a glove change and hand hygiene and picked up breadsticks with a glove that had touched contaminated surfaces. It was also noted the Culinary Coordinator was in the kitchen during the meal service when the above was observed and no correction occurred related to handling of ready to eat foods. 2. Continued observation also revealed several hamburger patties cooked on the flat top grill. The Culinary Coordinator used a spatula to remove one of the patties and placed it on a bun. He briefly touched the cooked hamburger patty with a bare hand to situate it on the bun. 3. Based on the Program's policy provided related to food service, the culinary team would meet the state and local laws related to preparation and service of food, including those in Iowa Code Chapter 137F. 4. When interviewed on 9/9/25 the Culinary Coordinator confirmed gloves should be worn when staff were handling ready to eat foods. He said there a cook that was not good at it previously but that staff was no longer there. He said there had been an improvement related to glove use.	A 150		
A 160	481-67.3(2) Tenant Rights	A 160		

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A 160	Continued From page 2 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide care, treatments and services that were adequate and appropriate. This pertained to 1 of 1 discharged tenant reviewed that had a fall with fracture (Tenant C1). Findings follow: 1. Record review on 9/4/25 of Tenant C1's file revealed an incident report dated 6/24/25 at 9:23 p.m. documented an unwitnessed fall in Tenant C1's apartment. The report indicated staff heard profanity coming from Tenant C1's apartment and, upon entering the apartment, found Tenant C1 on her buttocks, at the corner of her chair, pointed towards the door. Staff asked Tenant C1 what she was doing and Tenant C1 said she was going to the bathroom. The report further noted staff had stopped into her apartment at 9:00 p.m. and asked her if she was ready to get ready for bed. Tenant C1 said she could do it herself. Staff told Tenant C1 to stay where she was and she would be back shortly to help. The report noted Tenant C1 was assisted up with two staff and a gait belt. She was able to bend both knees to help assist her to standing. She initially complained of right hip and leg pain with weight	A 160		

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bearing. Tenant C1 ambulated to the bathroom and to bed. The vitals were recorded as follows: blood pressure 144/98, oxygen saturation 96%, pulse was 104, respiration rate was 22 and temperature was 96.8 degrees. They were recorded on the incident report on 6/25/25 at 12:35 p.m.; however, were reported to be vital signs at the time of the incident.

Continued record review of an Internal Investigation indicated on 6/24/25 at about 9:30 p.m. staff heard profanity from Tenant C1's apartment. Staff entered the apartment and found Tenant C1 on her buttocks, at the corner of her chair, pointed towards the door. Staff asked Tenant C1 what she was doing and Tenant C1 said she was going to the bathroom. The report indicated staff had stopped into her apartment at 9:00 p.m. to ask if she was ready to get ready for bed and Tenant C1 said she could do it herself. Staff told Tenant C1 to stay where she was and she would be back shortly to help. The summary indicated Tenant C1 resided in memory care and had a GDS of three. She required hands on assistance with ambulation with her walker., but did not require assistance with transfers. Staff completed a visual check at 8:17 p.m. At about 8:50 p.m. staff offered to help her to the bathroom and bed. Tenant C1 said she wanted to finish her movie first. At about 9:20 p.m. staff heard Tenant C1 yell and found on her between her recliner and bathroom. Staff assisted her to a standing position with a gait belt. Tenant C1 was able to stand and walk with weight on both legs. During the morning PT session the therapist reported she was not able to bear weight on the right leg. Tenant C1 was sent to the emergency department (ED) for evaluation and a pelvic fracture was found.

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A 160	Continued From page 4 Further record review of Employee Investigative Questions indicated Staff B was interviewed by the Executive Director on 6/26/25. She reported she stopped in at 8:50 p.m. to help Tenant C1 to bed. Tenant C1 watched television and said she wanted to finish her movie before bed. Staff B went to put away laundry in the laundry room. Staff A came to tell Staff B that Tenant C1 had fallen and it had not been more than 30 minutes since Tenant C1 saw her. Staff took her vital signs and used a gait belt to assist her up. Tenant C1 was able to walk and stand. Employee Investigative Questions indicated Staff A was interviewed by the Former Healthcare Coordinator on 6/25/25. Staff A said Tenant C1 got up on her own, fell and landed on her buttocks. 2. Record review of Tenant C1's file revealed was admitted on 6/2/25 and moved out on 6/25/25 with a billing end charge date of 7/27/25. She was staged at a three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline. The service plan dated 5/23/25 indicated she had chronic pain, she had scoliosis of her spine and low back pain was a constant problem for her. She rarely had acute pain. For mobility she required hands on assistance by staff when she used her walker. She required minimal assistance with transfers or positioning. Progress notes indicated the following: -On 6/25/25 at 10:32 a.m. the Former Healthcare Coordinator requested PT staff assess Tenant C1's right hip/leg due to complaints of pain that morning. PT assessed her and felt an x-ray would be needed as she was not bearing weight	A 160		

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on the right side. Tenant C1's POA was notified and would meet her at the hospital.

-On 6/25/25 at 12:32 p.m. it was noted on 6/24/25 at 9:23 p.m. staff heard profanity coming from Tenant C1's apartment. Staff entered the apartment and found Tenant C1 on her buttocks, at the corner of her chair pointed towards the door. Staff asked Tenant C1 what she was doing and Tenant C1 said she was going to the bathroom. The report indicated staff had stopped into her apartment at 9:00 p.m. to ask if she was ready to get ready for bed. Tenant C1 said she could do it herself. Staff told Tenant C1 to stay where she was and she would be back shortly to help.

-On 6/25/25 at 5:28 p.m. a nurse in the ED reported a pelvic fracture was found after numerous scans. She was being admitted to the hospital.

-On 6/26/25 the Former Healthcare Coordinator called the hospital for an update on Tenant C1 and was told she was doing well if she did not move.

-On 6/27/25 Tenant C1's family was in contact with the Executive Director and reported Tenant C1 would not be returning to the Program. They planned to move her belongings out on 6/30/25.

-On 6/29/25 a discharge summary was noted. Tenant C1's family "refuses to have her come back" to the program after a fall with fracture.

Continued record review revealed Tenant C1 was prescribed aspirin low dose 81 milligram (mg) delayed release, 1 tablet by mouth daily, Eliquis 5

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mg tablet, 1 tablet by mouth twice daily. She also had an order for acetaminophen 500 mg tablet, two tablets, by mouth, three times daily as needed. It was documented as administered on 6/24/25 at 6:12 a.m. and was documented as effective. The PRN record for Tenant C1 reflected the reason it was given as "Given." It was charted as effective at 8:08 a.m. (greater than one hour after given).

Further record review revealed there were no documented evaluations or assessments related to Tenant C1's fall on 6/24/25 completed by a licensed nurse on 6/24/25 or 6/25/25.

3. When interviewed on 9/8/25 at 2:13 p.m. Staff A reported she worked in memory care with Staff B. She was on one side and Staff B was on the other side. She said both staff had gone into Tenant C1's apartment and she was in her recliner and was watching a show. She seemed like she was on edge. About a half hour after she was observed in her recliner, Staff A stayed in the living room area and heard a crash and profanity from Tenant C1's apartment. Tenant C1 sat on the floor with her legs coming out of the bathroom door and her back against the wall. Her legs were straight out and she did not have her walker by her. She went and got Staff B in the laundry room and told her Tenant C1 had fallen. They went to her apartment with the vitals equipment. She was asked if she had pain and she said her leg (not sure where in her leg). The Former Healthcare Coordinator was called and told Tenant C1 had fallen. She directed staff to stand her up, take her vitals and send the vitals to her and to see if she had pain anywhere. Staff A said the Former Healthcare Coordinator did not say whether to use the lift. Staff A and Staff B

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lifted her up and took her vitals. The vital signs and the fact Tenant C1 had hip/leg pain was sent to the Former Healthcare Coordinator. They went ahead to see if Tenant C1 could walk, Tenant C1 limped and cried out in pain. She was assisted up, then to the toilet and limped to bed. She complained of her leg hurting her. Tenant C1 said she was putting on her nightgown and she thought staff was going to take a long time. Staff had told her they were coming back. She said she was going to do it herself. At the time of the fall she had her regular clothes on. After the fall, staff put her into her night clothing and changed her brief. Both staff lifted her off of the toilet. Staff A was pretty sure Tenant C1 ambulated with her walker back to bed. She said no pain medication was given on their shift. Third shift staff was made aware of Tenant C1's fall.

When interviewed on 9/8/25 at 3:04 p.m. Staff B said Tenant C1 preferred to go to bed at 9:00 p.m. At 8:50 p.m. she went to her apartment and asked if she wanted to go to bed and if she needed to go to the bathroom. Tenant C1 asked if it was okay if she watched a movie first. She was told staff would be back. Staff B went to fold laundry. A short time later, about 5-15 minutes later, Staff A came and told her Tenant C1 had fallen. Staff went to her apartment and she was observed on the floor, seated. Staff B said Tenant C1 had gotten up herself and went to bathroom. Her walker was by the toilet, where it had previously been by her recliner. Tenant C1's pajamas were sitting on the end of the recliner. Staff took her vitals and she complained of pain on her right side leg/hip area. Staff called the Former Healthcare Coordinator. The Former Healthcare Coordinator told staff to lift her up,

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take her vitals and ask if she was okay. She had pain in her leg and wanted to go to bed. Staff B said she had pain there since she had first moved in. Staff used a gait belt and assisted her up. She was seated on her chair and dressed in her pajamas and then assisted to bed. She was asked if she needed to go to the bathroom. Staff kept checking on her. She was asleep and seemed fine going to bed. She said third shift was made aware of the fall.

At attempt was made to interview Staff C, who worked first shift on the day following the fall; however, the interview attempts were not successful.

When interviewed on 9/10/25 at 10:11 a.m. and 10:45 a.m. Staff D said she worked first shift with Staff C that morning. They were told from third shift Tenant C1 had fallen. Staff asked if she was okay and were told yes. She said staff went into her apartment at 6:30 a.m. to check on her. Staff C and Staff D tried to get her up and she screamed. Staff called the Former Healthcare Coordinator and gave her two Tylenol. She said initially staff changed her in bed and later clarified that Staff C wanted to put her on the toilet and Staff D wanted to change her in bed. Staff did put her on the toilet. She was a pivot transfer into the wheelchair. She said she hurt when she was in bed and when she was transferred. She could not remember if Tenant C1 went out to the hospital with family or by ambulance.

When interviewed on 9/9/25 at 9:14 a.m. the Physical Therapist reported he had orders to see Tenant C1 for therapy and the first visit was planned for that day. He planned to see her later that afternoon, but received an email from the

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Former Healthcare Coordinator who asked if he could see her earlier that day due to a fall. He went to see her and she was in her wheelchair. He visited with the staff to see how she was that day, it was usually Staff C or Staff D but he was not sure who he talked to. He did not remember how the aide got her up and into the wheelchair. Staff reported she was in a lot of pain in her hip and she had a fall. He tried to be careful with her as she had a fall and had pain. With active range of motion (AROM) and passive range of motion (PROM) she had significant pain. She also had significant pain upon palpitation. It led him to believe it was a possible fracture. He had wheeled her from the memory care unit to the basement and back to memory care. He informed staff of the findings and suggested she would be sent out for imaging to rule out a fracture. Staff asked how the transfer went and he told staff he did not attempt a transfer due to suspected fracture. He said he also thought he called the Former Healthcare Coordinator of the findings. He asked the staff how to get her to the hospital, he was worried about a fracture and did not complete treatment with her. He thought they called an ambulance but he was not involved. He went to his next patient.

When interviewed on 9/8/25 at 3:43 p.m. and 9/10/25 at 2:32 p.m. the Former Healthcare Coordinator said Staff A called to report the fall before 10:00 p.m. on the same night. Staff A said they heard profanity from Tenant C1's apartment and saw her sitting on the floor at the corner of the recliner. Staff checked her vitals, moved her arms and legs and staff used a gait belt to get her up. Staff walked to her bathroom, got her dressed in pajamas. Staff had gone in before at 8:50 p.m. and Tenant C1 did not want to go to

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bed. She said there were nothing outside of normal limits related to her vital signs. She had complained of right leg and right hip pain but was walking normally. She had no marks or bruising. She thought she received scheduled pain medication (Tylenol) and she received a pain medication the next morning. Tenant C1's family was first notified at 5:00 a.m. of the fall. She noted family had a personal camera in the apartment and watched it all of the time. There were no further calls from staff until first shift called (next morning). She said Staff C called and reported Tenant C1 was in a lot pain and staff were not able to get her up. She was given Tylenol as needed. The Former Healthcare Coordinator sent an email to the Physical Therapist regarding her fall, had pain, was still able to walk and was not having a lot of pain. She asked the Physical Therapist to check on him. She said the Physical Therapist saw her and said she was not weight bearing and recommended she be seen for x-rays. Tenant C1 was sent by ambulance. She did not remember why she was not in the building that day. She said after multiple x-rays it was determined she had a pelvic fracture and she was admitted. An update was provided that indicated she was doing well unless moved, she did not have any pain. It was not surgically repaired and family decided to move her out of the program. The Former Healthcare Coordinator said she did not see her or assess her. Regarding why Tenant C1 was not sent out, she said once Tenant C1 was in bed she was okay, she was walking normally. She went to sleep, slept all night and the next morning she complained of pain and could not get out of bed. She later clarified she told staff to send her out and she was not aware Tenant C1 did not go out

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by ambulance until she read the ED report. She said when the ED report indicated it was an RTA bus it was the Program's bus. She said she did not call in a report because a report was given to emergency medical technicians and they passed it along.

When interviewed on 9/10/25 at 12:58 p.m. the Executive Director said she was not there that morning. She believed she was notified by phone by the Former Healthcare Coordinator that Tenant C1 had fallen at night. The next morning she was not weight bearing and was sent out to the hospital. She was told Tenant C1 had a fractured pelvis. She started staff interviews and put together the internal investigation. It was reported to the Department and was deemed a no investigation. She said the Former Healthcare Coordinator was not there at the time of the fall and she was sent out, regarding why an assessment was not completed.

4. Record review of an email was sent from the Former Healthcare Coordinator to the Physical Therapist on 6/25/25 at 5:18 a.m. It indicated Tenant C1 had a fall last night about 9:30 p.m. and landed on her buttocks. It was asked if the Physical Therapist could evaluate her that morning and see how she was doing. The Former Healthcare Coordinator indicated she would not be there until the afternoon as she was another assisted living building that morning. At 8:47 a.m. the Physical Therapist responded to the email and indicated he would evaluate her next.

Continued record review of email exchanges were provided between the Former Healthcare Coordinator and Tenant C1's power of attorney

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(POA). These include the following:

-On 6/25/25 at 5:15 a.m. the Former Healthcare Coordinator emailed Tenant C1's POA and indicated Tenant C1 took herself to the bathroom last night at about 9:30 p.m. She fell and landed on her buttocks. Staff heard her and went to her apartment. There was no bruising. She complained to right hip and leg pain but was able to walk. She notified therapy of the fall and they could evaluate her today.

-On 6/25/25 at 9:02 a.m. Tenant C1's POA responded and asked if the staff had not helped her to bed by 9:30 a.m. It had been discussed that she needed to get to bed by 9:00 p.m. at the latest. It was noted Tenant C1 got tired and impatient. She indicated she wanted evaluated today and that she would be there to check on her.

-On 6/25/25 at 9:16 a.m. the Former Healthcare Coordinator responded and indicated staff struggled for Tenant C1 to allow them to get ready and in bed early. They continued to go in and ask her. The staff were fearful of making it seem like they were forcing her. She indicated the staff were consistent but she wished it was a more consistent routine. She also indicated the therapist would be check on her shortly.

-On 6/26/25 at 3:33 p.m. Tenant C1's inquired about more information related to Tenant C1's fall had various questions.

Further record review revealed a screenshot of a text message exchange between Staff A and the Former Healthcare Coordinator was provided. It included a picture of a paper with vital signs

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CLOVER RIDGE PLACE	205 EHLERS LANE MAQUOKETA, IA 52060

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recorded as follows: blood pressure 144/119, oxygen saturation 96%, pulse was 104, respiration rate was 22 and temperature was 96.8 degrees. It also noted she was found down at 9:23 p.m. and had right leg/hip pain. The Former Healthcare Coordinator asked if there was any bruising and Staff A responded there was no bruising. The Former Healthcare Coordinator said thanks. The next message was on 6/25/25 at 11:48 a.m. the Former Healthcare Coordinator asked Staff A to call her right away so she could ask her questions about the fall the night prior.

5. Record review of a Physical Therapy Initial Evaluation and Treatment document dated 6/25/25 indicated Tenant C1 was referred to physical therapy (PT) on 6/24/25. It was noted she had recently move from her home into an assisted living. She had a stroke in the past that had affected the sensation and strength in her right lower extremity, which had to falls. Staff reported she fell on her buttocks at about 9:30 p.m. on 6/24/25. Staff also reported she had not been out of her wheelchair since due to the pain in the right hip. It indicated Tenant C1 was not able to perform sit to stand transfers from a wheelchair due to her compromised pain level. She was not able to transfer at that time related to increased pain on the right hip with weight bearing. The assessment indicated she was "severely limited in functional mobility tasks, including AMB and transfers, d/t R hip pain. Her pain sharply with palpation of R hip soft tissue and R greater trochanter, during limited AROM of B hips, and during PROM of R hip. Along with aforementioned pain, pt (patient) also unable to bear weight on R LE, the pt is suspected to have sustained a R hip Fx during the fall, and nursing

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staff informed of findings." It was also noted the findings of the evaluation pointed to possible right hip fracture, included right hip pain when at rest, she was not able to bear weight through the right lower extremity, the was swelling in the right hip and the right hip was noted to be tender with palpitation. Tenant C1 and nursing staff were educated to avoid weight bearing on the RLE until a right hip fracture was ruled out through imaging.

Continued record review of hospital records indicated she arrived at the hospital in private vehicle in a wheelchair. On 6/25/25 at 11:03 a.m. the chief complaint indicated she fell yesterday, had right hip pain. The program sent her in a RTA bus and no reported was called in. Tenant C1 was unsure why she was in the ED. She had fall night, before 9:00 p.m., over 12 hours prior. Her POA was at bedside and reported that Tenant C1 was prescribed Eliquis. She complained of right hip and right knee pain and could not bear weight on the lower extremity in the ED. The onset was one day ago. Character of symptoms was pain and the degree at onset was noted as severe and the degree at current was severe. It was also noted Tenant C1 had dementia and history of a prior CVA per the POA. An x-ray was negative but a computed tomography (CT) was completed and indicated a superior and inferior pubic rami fracture and sacral alla fracture. The diagnoses included accidental fall, fracture of multiple pubic rami, closed sacral fracture. Tenant C1 was admitted to the hospital.

Further record review of hospital records indicated the Discharge Summary indicated she fell and sustained "nondisplaced fracture of the

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right pubic acetabular junction and minimally displaced fracture of the right interior pubic ramus, nondisplaced right sacral alla fracture. It was recommended after an orthopedic consult that Tenant C1 would be admitted for skilled therapy as the fractures were non-operable. She was initially admitted for "intractable pain and therapy." She went to skilled therapy for her stay for ongoing therapies. She was ready to be discharged and would be going to care center for skilled therapies and would plan to transition to long-term care. The discharge date was 7/7/25.

In summary, Tenant C1 sustained a fall on 6/24/25 at approximately 9:23 p.m. She was found on the floor in her apartment after an unwitnessed fall. Staff responded, called the Former Healthcare Coordinator, took her vital signs and assisted her up with two staff and a gait belt. It was noted her blood pressure of 144/119, pulse was 104 and respiration rate was 22. Tenant C1 also complained of hip/leg pain. Per Staff A's interview Tenant C1 cried out and limped when staff assisted her. She was assisted to the bathroom and to bed. Staff also changed her into pajamas. Tenant C1 was not sent to the hospital for evaluation despite complaints of pain, having an unwitnessed fall. She was also prescribed anticoagulants and was staged at a three GDS. Tenant C1's family was not notified of the fall until about 5:15 a.m. and was notified by email. The Former Healthcare also emailed a Physical Therapist that was scheduled to see Tenant C1 that day and asked if he could check on her and evaluate her. The next morning it was reported to the Former Healthcare Coordinator that Tenant C1 would not get out bed and was in a lot of pain. Staff D said when staff tried to get Tenant C1 up she

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A 160	Continued From page 16 screamed in pain. Staff C administered Tylenol as needed, no reason was charted except that it was given and the effectiveness was charted more than one hour after it was administered. The Physical Therapist noted in the visit note that staff reported she had not been out of her wheelchair due to the pain in the right hip. It indicated Tenant C1 was not able to perform sit to stand transfers from a wheelchair due to her compromised pain level. She was not able to transfer at that time related to increased pain on the right hip with weight bearing. It was also noted the findings of the evaluation pointed to possible right hip fracture, included right hip pain when at rest, she was not able to bear weight through the right lower extremity, the was swelling in the right hip and the right hip was noted to be tender with palpitation. Tenant C1 and nursing staff were educated to avoid weight bearing on the right lower extremity until a right hip fracture was ruled out through imaging. An evaluation by a licensed nurse was not completed related to Tenant C1's fall, including the night of her fall on 6/24/25 or the next morning on 6/25/25. Per hospital records, Tenant C1 arrived at the hospital in a wheelchair after being dropped off by a bus, a report was not called in prior to her arrival and she did not know why she was there. It was determined she had "outdistanced fracture of the right pubic acetabular junction and minimally displaced fracture of the right interior pubic ramus, nondisplaced right sacral alla fracture." She was admitted, the fractures were not operable. She was discharged from the hospital on 7/7/25 to skilled care with the plan to transition to long term care. Tenant C1 did not receive care, treatment or services that were adequate and appropriate post fall.	A 160		

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A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on interview and record review the Program failed to have staff provide services in accordance with training provided. This pertained to 1 of 3 direct care staff interviewed (Staff D). Findings follow: 1. When interviewed on 9/10/25 at 10:11 a.m. and 10:45 a.m. Staff D she said a gait belt was used for Tenant #5 with a walker. She left the gait belt around her but unsnapped it at meals, while she was eating. She said it would be left on for 30 to 45 minutes. She said there had not been tenant complaints about it. When interviewed on 9/8/25 at 2:13 p.m. Staff A said Tenant #5 and Tenant #2 used a gait belt. She said she removed it right after. She had seen a couple of times it was left on for a time period and she took it off right away. She said it was mostly the newer staff and they did not know to take it off. She said Tenant #5 would play with the gait belt. Staff had training on gait belt use. When interviewed on 9/8/25 at 3:43 p.m. the Former Healthcare Coordinator said all staff had been delegated on gait belt use. She said when	A 361		

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A 361	Continued From page 18 staff got done, regarding when the gait belt should be removed. She was not aware of staff leaving gait belts on tenants. 2. Record review on 9/10/25 of Staff D's delegations indicated she was delegated on the Slide Board (provided training on transferring with a gait belt) and using a Gait Belt for Ambulation both dated 7/12/25. Continued record review revealed the Slide Board (instructions for gait belt use within this delegation) indicated to remove the gait belt when the transfer and ambulation was completed. It indicated leaving the gait belt on when the tenant was at an activity or in the dining room did not promote dignity. 3. When interviewed on 9/10/25 at 12:58 p.m. the Executive Director confirmed staff were trained on the use of gait belts with delegations. It was to be removed once the transfer was complete.	A 361		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.	A 350		

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A 350	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service and have service plans reflect service needs of the tenants. This pertained to 1 of 4 current tenants reviewed (Tenant #4) and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow: 1. Record review on 9/8/25 of Tenant #4's file revealed Progress Notes indicted the following: -On 6/7/25 it was noted staff call triage and reported Tenant #4 had an unwitnessed fall. Staff reported Tenant #4 laid down in the hallway on the floor to take a nap. No injuries were noted and Tenant #4 was assisted up from the floor. -On 9/6/25 it was noted staff called triage and reported Tenant #4 was observed laying on the floor. She had a small skin tear above her right ear, which was cleaned by staff. Continued record review revealed reflected Tenant #4's service plan dated 6/7/25 indicated staff was to assist Tenant #4 as she was blind and was not able to see where to go. It indicated she had a fall potential and general items were listed to ensure wearing proper footwear, keeping walkways free of clutter and reminders to call for assistance. There were no other individualized interventions related to Tenant #4's falls or being found on the floor. 2. Record review on 9/8/25 of Tenant C2's file revealed Progress Notes indicated the following: -On 8/21/25 it was noted a change of condition was completed. Hospice was there to admit her	A 350		

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A 350	Continued From page 20 to hospice services. She had raw area at the top of her buttocks and staff would apply a topical cream twice daily. She had started pocketing food and let fluids run out of her mouth. Hospice was considering a Foley catheter to help keep skin dry. The Hospice aide would provide bed baths. -On 8/22/25 it was noted Tenant C2 was no longer able to swallow. -On 8/23/25 it was noted Tenant C2 died. Continued record review revealed Tenant C2's service plan reflected she preferred to consume foods of her choice and staff encouraged fluids throughout the day. It indicated hospice provided bed baths. The service plan did not address the raw area as noted in notes or the treatment. It also did not reflect the pocketing of food or fluids running out of her mouth. The service plan reflected hospice assisted with bathing but did not reflect other hospice services provided. 4. When interviewed on 9/10/25 at 12:58 p.m. the Executive Director confirmed all service plans were provided for the tenants reviewed in the time period requested.	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER S0078	DATE SURVEY COMPLETED: 9/10/2025

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Tag #1	**481-67.2(3) Program Policies and Procedures** 67.2(3) The program shall follow the policies and procedures established by the program This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to follow established food policy and procedure. This potentially affected all tenants (census of 45).	**Tag # A150**	All staff will receive re-education on safe food handling by 01/11/2026.	All new employees will complete Safe Food Handling training within 30 days of hire. The new Culinary Coordinator will complete Safe Food Handling and ServSafe training within 30 days of hire. The Director or designee will complete routine audits of the kitchen/dining rooms during meal service time to ensure compliance.	**Implementation Date:** 10/14/2025 **Completion Date:** Ongoing **Responsible Party: Director or designee**
Tag #2	**481-67.3 Tenant rights.** All tenants have the following rights:	**Tag # A160**	All medication delegated staff, The Director and HCC will receive education on PRN Medication Administration and follow up expectations by 1/11/2026.	All new hires will receive training on appropriate transportation in emergent situations within 30 days of hire.	**Implementation Date:** **10/14/2025**

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

	67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide care, treatments and services that were adequate and appropriate. This pertained to 1 of 1 discharged tenant reviewed that had a fall with fracture (Tenant C1).		All staff will receive education on safe and appropriate transportation in emergent situations by 1/11/2026. The Director and HCC will be reeducated on the Incident Report Expectations related to falls to include timely notification to POA/PCP by 1/11/2026. The Director and HCC will be reeducated on the emergency transfer process and change of condition expectations and time points by 1/11/2026. The Director and HCC will receive education regarding communication expectations/documentation with emergent situations/incidents by 1/11/2026.	All new hire medication passers will receive training on PRN Medication Administration and follow up expectations prior to administering medications in the community. The Director or designee will complete routine audits of resident's ER visits to ensure safe and appropriate transportation was utilized and report was called to the hospital by the nurse to ensure compliance. The Director or designee will complete routine audits of incident report notification logs to ensure compliance. The Director or designee will complete routine audits of EMAR documentation to ensure timely follow-up is documented for PRN medications that have been administered. The Director or designee will complete routine audits of Change of Condition assessments to ensure	**Completion Date:** Ongoing **Responsible Party: Director or designee**

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				assessment was completed and completed in a timely manner.	
Tag #3	**481-67.9(4)f Staffing** 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on interview and record review the Program failed to have staff provide services in accordance with training provided. This pertained to 1 of 3 direct care staff interviewed (Staff D).	**Tag #A361**	The Gait Belt Delegation form was revised on 10/24/2025 to reflect the removal of the gait belt from the resident task. All staff will receive training on the revised version of the Gait Belt Delegation by 1/11/2026.	All new hires will be trained on the revised Gait Belt Delegation with care delegations by the HCC within 30 days of hire. The Director or designee will complete routine audits of gait belt transfers to ensure compliance.	**Implementation Date:** **10/14/2025** **Completion Date:** Ongoing **Responsible Party: Director or designee**
Tag #4	**481-69.26(1) Service Plans** 69.26(1) A service plan shall be developed for each tenant based on the	**Tag #A350**	Tenant C2 passed away on 8/23/2025. Tenant 4's service plan will be updated by 1/11/2026 to reflect the behavior of placing herself on the floor and any other	The Director or designee will complete routine audits of incident reports, change of condition assessments and service plans to ensure compliance.	**Implementation Date:** **10/14/2025** **Completion Date:**

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	evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service and have service plans reflect service needs of the tenants. This pertained to 1 of 4 current tenants reviewed (Tenant #4) and 1 of 2 discharged tenants reviewed (Tenant C2).		behaviors she may have with interventions for staff. An audit of all current tenants' service plans will be completed by 1/11/2026 to ensure all residents who exhibit behaviors have the specific behavior with interventions for staff on the service plan. The Director and HCC will receive re-education regarding Service Plan expectations and change of condition expectations and time points by 1/11/2026.		Ongoing **Responsible Party: Director or designee**

Compliance Date: 01/11/2026

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