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 03/12/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 30 Tenants with cognitive impairment: 15 Total census: 45 The following regulatory insufficiencies were cited related to the investigations of Complaints #130416-C; #130426-C and #131050-C. The following regulatory insufficiencies were re-cited at 67.3(2) and 69.26(1) related to the revisit of FC#10976 (9/10/25 for Complaint #129912-C and #130006-C).	A 000		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide care, treatment and services that were adequate and appropriate. This pertained to 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow:	A 160		

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

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 03/12/2026

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

(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 160	Continued From page 1 1. Record review on 3/10/26 and 3/11/26 of Tenant C1's file revealed an incident report dated 9/19/25 at 4:30 p.m. indicated Staff A went to Tenant C1's apartment to wake her up for supper and Tenant C1 was non-responsive. Her vitals were taken, a blood pressure was not able to be obtained, her heart rate was 24 and oxygen saturation was 80 percent (%) and dropping. Staff was instructed to call 911 to transport Tenant C1 to the hospital. Tenant C1's power of attorney (POA) was notified and would meet her at the hospital. Continued record review revealed Progress Notes indicated the following: There were no entries in September prior to the 9/16/25 nurse's note. -9/16/26, Tenant C1 received the flu vaccine and it was well tolerated. -On 9/19/25, Staff A went to Tenant C1's apartment to wake her up for supper and Tenant C1 was non-responsive. Her vitals were taken, a blood pressure was not able to be obtained, her heart rate was 24 and oxygen saturation was 80% and dropping. Staff was instructed to call 911 to transport Tenant C1 to the hospital. Tenant C1's POA was notified and would meet her at the hospital. -On 9/19/25, a report was given from the hospital indicating Tenant C1 was actively dying and was transferred to the unit for comfort care. -On 9/19/25, a discussion was held with Tenant C1's POA. It was reported Tenant C1 was alert and at baseline.	A 160		

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 03/12/2026

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

(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 160	Continued From page 2 -On 9/22/25, Tenant C1 returned from the hospital and there were new orders for hospice. -On 9/23/25, Tenant C1 was alert, awake and non-verbal. Tenant C1 was bed bound. -On 9/30/25, hospice visited today and Tenant C1 had cool extremities with some mottling noted. Tenant C1 continued to pocket food and ate a small amount of soft food. -On 10/02/25, Tenant C1 was unable to swallow her medications, applesauce or water. -On 10/02/25, all oral medications were discontinued. Lorazepam and morphine were started. -On 10/03/25, Tenant C1 died. Her comfort medications had not been given as they had just arrived from the pharmacy. Continued record review revealed Tenant C1's file indicated her diagnoses included: dementia without behavioral disturbance and urinary tract infection (9/22/25). Tenant C1 was staged at a six on the GDS, on 3/20/25, which indicated severe cognitive decline then a seven on 9/22/25, which indicated very severe cognitive decline. Tenant C1 resided in the memory care unit. Tenant C1's service plan, dated 3/20/25, reflected the following cares were in place as of 9/19/25 when she was found non-responsive: staff administered her medications, she required total assistance with dressing, total assistance with toileting. Staff was to toilet Tenant C1 four times per shift. Tenant C1 was incontinent of bladder and bowel. The service plan indicated Tenant C1	A 160		

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 03/12/2026

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

(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 160	Continued From page 3	A 160		

had a history of UTIs and staff were to monitor for signs and symptoms including pain, frequency, urgency, burning, foul odor, incontinence, dizziness, weakness and confusion. Staff were to report changes to the nurse and if symptoms were noted to encourage fluids. Tenant C1 wore a protective undergarment. Tenant C1 required total assistance with eating and her food cut into small pieces. Tenant C1 required assistance of one person with a gait belt and walker. She also required total assistance with grooming, hygiene and bathing. Tenant C1 required visual/safety checks eight times per shift.

Further record review revealed the September 2025 Monthly Task reflected cares were signed off as completed from 9/16/25 (received her flu shot) through 9/19/25 (when found non-responsive): daily bed making and daily trash removal. Transferring assistance was signed off as completed on all three shifts on 9/16/25, 9/17/25 and 9/18/25. It was signed off as completed on first shift on 9/19/25. The second and third shift transferring assistance were marked as out of facility. Dressing assistance was signed off as completed on 9/16/25, 9/17/25, 9/18/25 both a.m. and p.m. shifts. On 9/19/25, dressing assistance was marked off as completed for the a.m. and out of facility on the p.m. shift. Toileting assistance was scheduled four times per shift and staff signed off once for all toileting provided on each shift. Toileting assistance was signed off on 9/16/25, 9/17/25 and 9/18/25 on each shift, which indicated four times per shift. On 9/19/25 toileting was signed off on 9/19/25 for first shift, which indicated four times per shift. The second and third staff toileting tasks were noted as out of facility. Bathing was signed off as completed on 9/18/25. It was signed off as task not completed on

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 03/12/2026

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

(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 160	Continued From page 4	A 160		

9/11/25. Meal consumption assistance was signed off for all three meals on 9/16/25, 9/17/25, 9/18/25 and for the breakfast and noon meal on 9/19/25. Staff also signed off for the completion of daily activity reminders or assistance with activities on twice per day (a.m. and p.m. shifts) on 9/16/25, 9/17/25, 9/18/25 and on first shift on 9/19/25. Visual checks were signed off as completed every hour on 9/16/25 through 9/19/25 at 3:00 p.m.

It should be noted the surveyor requested time stamped task logs to indicate when the assigned tasks were signed off by staff. These records could not be provided in the electronic medical records system.

Continued record review revealed there were no staff to nurse communication sheets for Tenant C1 during that time frame or in the three months prior to her discharge. There were also no nurse's notes completed between 9/16/25 (when she received her flu shot) until the incident report note on 9/19/25 when Tenant C1 was found non-responsive.

Record review on 3/11/25 revealed Tenant C1's hospital records included the Prehospital Care Report indicated at 4:35 p.m. the ambulance was dispatched to the Program. Upon arrival to the Program, staff reported Tenant C1 had shortness of breath. Her oxygen saturation was 80 and declining. Her pulse was 24 and declining. Staff was asked if Tenant C1 had eaten anything today and staff responded she must have as the staff have to feed her. Tenant C1 was laying in bed. She was reported to be non-verbal (baseline). She was transported to the ambulance. Vitals were taken and indicated: pulse was 72, respiratory rate was 14, blood pressure was

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 03/12/2026

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

(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 160	Continued From page 5	A 160		

125/58. Oxygen saturation was 96 %. Hospital records indicated Tenant C1 was non-verbal, did not follow commands and did not assist with movement. Program staff could not state what her baseline was and they did not know the last time she ate or ambulated. They did not know if she talked or not as her baseline. "Patient has visible pus in her depends. Her urine is brown and purulent. Patient has a very potent foul odor from having soiled herself." It was unknown the last time she was seen well. "Based on patient's presentation with severe encephalopathy, presumed severe sepsis from urinary tract infection." The records indicated the assessment/plan was acute metabolic encephalopathy (likely secondary to sepsis from UTI, admission for end of life care, acute cystitis with hematuria, bradycardia and hypoxia. It was noted "Complicated UTI" and "Severe dehydration." The plan was to be discharged back to the Program on Monday with hospice care. The urinalysis indicated the following: urine color was brown, clarity was turbid, ketones were 40, bilirubin were large, urobilinogen was 4.0, protein was greater than 300, blood was large, leukocytes large, nitrates positive, which were all noted as abnormal. The bacteria was indicted many/high power field (HPF), white blood cell count was greater than 50/low power field (LPF) and red blood cell count greater than 50 HPF., Tenant C1's family had last seen her a week or so ago. Tenant C1 fingers/hands "noted to be contracted et mottled, depends heavily soiled et foul smelling with puss (sic) visualized, puss/thick brown-red urine also noted with catheterization vague report received from care center et unknown last known well et unknown last time she ate or had PO interventions." Tenant C1's family did not want intravenous interventions or life-sustaining procedures. Her weight was noted

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 03/12/2026

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

(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 160	Continued From page 6 as 87 pounds. Further record review revealed Tenant C1's weight was 94 pounds on 9/01/25 and she was noted to weigh 87 pounds at the hospital on 9/19/25. When interviewed on 3/11/26 at 1:34 p.m. Staff D (worked first on 9/19/25) only remembered Tenant C1 was ill, very sick, maybe the flu or something. She did not remember if the nurse was contacted. Staff checked on her every hour and tried to feed her. Staff D indicated Tenant C1 always came out to the dining room for meals. For toileting Tenant C1 required total care, staff did everything for her and changed her protective undergarments. She could not recall if Tenant C1 had any UTI symptoms at that time but indicated in general the nurse would be notified, so antibiotics could be started for people with UTIs. When interviewed on 3/12/26 at 9:03 a.m. Staff A reported from what she could remember she went to check on Tenant C1 and she was non-verbal (baseline). There was nothing there (on her face) at all. Staff A reported something was not right. Staff A thought she told the nurse and Tenant C1 was sent out to the hospital. She did not provide care to Tenant C1 prior to supper as Tenant C1 was napping. Staff A reported Tenant C1 would have been laid down to nap at about 2:00 p.m. Staff completed visual checks but did not wake her. Tenant C1 required total care and required assistance with toileting including changing of her briefs. Tenant C1 was very incontinent of bladder and bowel. She could not recall if there was any communication for Tenant C1 from the prior shift. She indicated people were saying the week prior that Tenant C1 was not standing up for them and would push	A 160		

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 03/12/2026

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

(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 160	Continued From page 7 them away. When interviewed on 3/12/26 at 11: 45 a.m. the Former Healthcare Coordinator recalled an unresponsive incident with Tenant C1 but she was not sure if she got the telephone call or if triage was called. The Former Healthcare Coordinator indicated Tenant C1 was unresponsive and came back on hospice care. The Former Healthcare Coordinator reported she was only employed a short time at that point. The Former Healthcare Coordinator did not recall one way or another if she was notified of any changes or concerns with UTI symptoms. The Former Healthcare Coordinator indicated she would have charted on it and would have asked for a UA. The Former Healthcare Coordinator believed Tenant C1 required almost full assistance, staff helped with brief changes and with eating, but she was not 100% sure. Further record review of Tenant C1's file reflected cares were signed off as completed including on the day Tenant C1 went to the hospital. The care included toileting, eating, dressing, visual checks, hygiene and grooming. This included hourly visual checks, two meals on 9/19/25 and toileting (scheduled four times per shift) including four times on the first shift. Additionally, the service plan and task records reflected the history of UTIs and to monitor for signs and symptoms. When found on 9/19/25 before supper Tenant C1 had no measurable blood pressure per the Program's incident report and was non-responsive at 4:30 p.m. Upon arrival to the hospital, Tenant C1's hands were contracted and there was mottling noted on her skin. Her protective undergarment was heavily soiled and she was severely dehydrated. She had severe sepsis likely secondary to a UTI and was	A 160		

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 03/12/2026

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

(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 160	Continued From page 8	A 160		

admitted to end of life care. In addition, upon evaluation there was visible pus noted in her protective brief, her urine was brown and purulent. Program staff could not answer questions from hospital staff related to the time she was last seen well, when she had last ambulated, ate or had fluids. Tenant C1 returned from the hospital on hospice services and was bed bound. Her oral medications were discontinued on 10/02/25 due to swallowing difficulties and lorazepam and morphine were ordered. Tenant C1 died on 10/03/25 and had not been administered the comfort medications as ordered and had all oral medication discontinued. Tenant C1 did not receive care, treatment and services that were adequate and appropriate related to the provision of care, observation and reporting of a change of condition to the nurse and administration of comfort care medications at end of life.

2. Record review on 3/10/26 to 3/12/26 of Tenant C2's file revealed an incident report dated 9/14/25, indicated at 7:47 a.m. staff reported Tenant C2 had an elevated temperature of 100.6 degrees. Tenant C2's POA was notified and requested Tenant C2 be sent to the hospital.

An incident report dated 9/14/25, indicated at 1:30 p.m. Tenant C2 had just returned from the hospital and was told she had a virus. Staff called to report Tenant C2 had an unwitnessed fall. The incident report noted Tenant C2 was going to pick up her tray and fell. The left hip pain was rated 10/10. Tenant C2 had on shoes but did not have her walker. Her heart rate was 103, blood pressure was 103/63 and oxygen saturation was 93%. The face sheet and emergency transfer sheet were provided to emergency medical services (EMS).

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 03/12/2026

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

(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 160	Continued From page 9 Continued record review revealed an Internal Investigation indicated on 9/14/25 at 1:30 p.m. staff called triage and reported an unwitnessed fall. Tenant C2 went to pick up her tray and fell. Her left hip pain was rated at 10/10. She was wearing shoes but did not use her walker. Tenant C2 was independent with ambulation and consistently refused to use her walker. She had returned from the hospital earlier in the day and was told she had a virus. It was determined Tenant C2 sustained a fractured left hip. It was documented the allegation included staff statements and service plan. Staff A was interviewed. It was determined Tenant C2 was not feeling well during the day, she was sent to the emergency department (ED) and returned immediately. Tenant C2 ambulated within her apartment and staff responded. Follow up with the hospital indicated she fractured her left hip and the family elected for surgical repair. It should be noted staff interviews and/or statements as indicated in the investigation were requested and were not available. Record review on 3/10/26 to 3/12/26 of Tenant C2's file revealed diagnoses included osteoarthritis, dislocation of left shoulder, other symptoms and signs involved cognitive functions and awareness. Tenant C2 was staged at a four on the GDS, which indicated moderate cognitive decline. She resided in the memory care unit. Continued record review revealed Progress Notes indicated the following: -On 9/14/25 at 7:47 a.m., staff called and reported Tenant C2 had an elevated temperature and congestion. Her oxygen saturation was 91%	A 160		

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 03/12/2026

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

(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 160	Continued From page 10	A 160		

and temperature was 100.6 degrees. Tenant C2 POA was notified and requested transport to the ED.

-On 9/14/25 at 1:30 p.m., staff called to report an unwitnessed fall. Tenant C2 went to pick up her tray and fell. No head strike was reported but her pain in the left hip was 10/10. Tenant C2 had just returned from the hospital where she was told she had a virus.

-On 9/15/25, a nurse followed up with hospital staff and was told Tenant C2 was currently in surgery for the left fractured hip.

-On 9/16/25, a nurse followed up with hospital staff and was told Tenant C2 had no pain, started to work with therapy and walked with the assistance of one person and a walker. Tenant C2 had tested positive for COVID-19 prior to surgery.

-On 9/18/25, Tenant C2 moved out on 9/17/25 and moved to a long-term care facility.

When interviewed on 3/12/26 at 9:03 a.m. Staff A reported Tenant C2 had a left-hand splint. Staff A could not recall what occurred with bathing but said at first Tenant C2 struggled with eating. Staff assisted and guided Tenant C2's other hand. She said when Staff A came on first shift third shift staff reported Tenant C2 was coughing, felt hot but did not have an elevated temperature and felt fine. Staff A checked on her and Tenant C2 had a raspy voice and felt fine. Tenant C2's temperature was very elevated. Staff A called it into triage, an ambulance was called and Tenant C2 was sent out. Staff A did not see Tenant C2 when she returned to the Program but Tenant C2 returned on Staff A's shift. The other staff told Staff A it was

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 03/12/2026

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

(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 160	Continued From page 11	A 160		

viral but Tenant C2 still had a temperature. Staff A asked Tenant C2 if she wanted to use the bathroom and if she wanted to eat in her apartment for lunch. Staff A put in Tenant C2's meal order and took her to the bathroom. Staff A took Tenant C2 the meal tray for lunch, it was put on the side table and her plate was put into her lap. Staff A gave Tenant C2 the button (pendant). Staff A walked out and took other tenants to their apartments. Staff A was in with another tenant and heard yelling for help. Staff A ran to Tenant C2's apartment and observed her on the ground, her tray sat on the ground and nothing had spilled. Tenant C2 was laying on both hands, including her previously fractured hand. Staff A tried to get her on her back. Staff A could not find the other staff, she called triage (it was not going through; she could not remember). She was able to reach someone at some point over the phone and they could barely have conversation due to Tenant C2's screaming. Tenant C2's vitals were not coming back and it was reading an error. Staff A reported she thought it was because Tenant C2 was panicked and crying. Staff A reported Tenant C2 was lying face down on both hands including the fractured hand. Staff A moved her to her back and Tenant C2 sat herself up to her buttocks using the wall. Staff A reported she did not remember who came in but Staff A thought the other staff helped her lift Tenant C2 into the wheelchair. It was put underneath Tenant C2 and she did not move at all. Staff A could not remember if she or triage called EMS but they arrived and completely lifted Tenant C2 onto the cot. Staff A indicated if she remembered correctly Tenant C2 was screaming to get her up off the ground and Staff A was pretty sure she was told (by triage) if Tenant C2 was uncomfortable to get her up. Staff A Tenant C2 did not use her pendant to call for assistance and Staff A last saw Tenant

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 03/12/2026

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

(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 160	Continued From page 12 C2 approximately 30 to 45 minutes prior. When interviewed on 3/12/26 at 11:23 a.m. Staff B indicated she worked with Staff A in memory care on first shift. Earlier in the shift Tenant C2 was sent out. She returned and had a cold or pneumonia. Tenant C2 was coughing, was weak and did not feel well. Tenant C2 was in her recliner, the television was on and she had water. The next time Staff B saw Tenant C2 she had fallen. Staff A yelled down that Tenant C2 had fallen. Staff B responded and observed Tenant C2 seated with her back up against the recliner. Tenant C2 did not complain of pain. Staff A took the vitals. Staff B indicated Tenant C2 did not want to be on the floor. Staff A called triage and was told to call EMS. Staff B indicated she did not see Tenant C2 moved from the seated position with her back against the recliner. Staff B did not assist with a transfer with Tenant C2. Staff B indicated Staff A had called Staff C for assistance. Tenant C2 had a motion alarm (chair/floor) that made a loud noise when she moved about. The alarm was going off when Staff B came into the apartment. The meal tray was on the floor, tipped over. There was not a mess. Staff B thought she wrote a statement or was interviewed by the Former Healthcare Coordinator regarding the incident. When interviewed on 3/12/26 at 12:27 p.m. Staff C indicated she worked in assisted living and was called back to memory care by Staff A. Staff C indicated she was completing a task and went to memory care. There were two staff in memory care, Staff C thought it was Staff A and Staff B. When Staff C went to the apartment, Tenant C2 was seated in a chair, Staff C was not sure if it was a wheelchair or recliner but Tenant C2 was in a chair. Staff C did not assist with the transfer of	A 160		

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 03/12/2026

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

(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 160	Continued From page 13 Tenant C2. When interviewed on 3/12/26 at 11:45 a.m. the Former Healthcare Coordinator reported she was not involved with the fall with a fracture for Tenant C2. She indicated the protocol was for staff to call triage or the nurse and direction was provided to staff (regarding fall protocol). The Triage Nurse with the management company who documented the incident in progress notes was on paid time off per corporate staff and was not able to be interviewed before the investigation was closed. Further record review revealed hospital records (hospital #1 records) from the ED visit on 9/14/25, indicated Tenant C2 had a history of dementia, and came to the ED after having a fever. Her vital signs were stable, she was afebrile and received an antipyretic. The white blood cell count was normal. The chest x-ray showed no acute cardiopulmonary processes. The record noted most likely it was viral. The hospital records indicated two attempts were made to call a report to the Program without success, there was no answer. Tenant C2 was discharged back to the Program, she was told to follow up with her provider in one to two days and to return to the ED if anything changed or worsened. Continued record review revealed hospital records (hospital #2 records) from the hospitalization (post fall) on 9/14/25 included a Prehospital Care Report indicated at 1:36 p.m. the ambulance was dispatched to the Program and arrived on scene at 1:46 p.m. Tenant C2 had a fall with left hip pain. The crew were met by staff who took them to Tenant C2's apartment. "The pt was found sitting in a chair." The staff	A 160		

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 03/12/2026

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

(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 160	Continued From page 14	A 160		

reported Tenant C2 had a ground level fall that resulted in her landing on her left side/hip. The staff was able to get her into a chair and said Tenant C2 could not put any weight on the left leg and her pain rated at 10/10. The crew was able to stage the cot and lift her from the chair to the cot. Once she was on the cot the crew attempted to straighten her leg but Tenant C2 cried out in pain. Her hip was palpitated and it was tender in the mid-thigh on the left side. The crew contacted Tenant C2's POA who requested if it was thought to be broken to transport to a non-local hospital. Hospital records indicated Tenant C2 was admitted on 9/14/25 and discharged on 9/19/25. Final diagnoses included displaced fracture of base of neck of the left femur, pneumonia due to COVID-19, acute respiratory failure with hypoxia and COVID-19. The records indicated she presented to the ED for evaluation post fall with severe hip pain. She fell a few weeks prior, she had a head laceration, bruising and a hand fracture. She fell on 9/14/25 had hip pain 10/10 and was not able to ambulate. She had been seen in an ED earlier on 9/14/25 due to not feeling well. She was only back about an hour when she fell and sustained an injury to her left hip. Tenant C2 had the hip surgically repaired (left hip arthroplasty). On 9/18/25, Tenant C2 oxygen saturations were low and she was not responding to oxygen therapy. Her breathing was very wet sounding and she coughed intermittently. On 9/19/25, Tenant C2 died with family at her side. The immediate cause of death was acute hypoxic respiratory failure, secondary dementia, left hip fracture and COVID pneumonia.

Record review of the Program policy and procedure for Safe Handling indicated a medical assessment was completed by the nurse in house or by telephone. If there was a medical

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 03/12/2026

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

(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 160	Continued From page 15 concern, EMS was called and the tenant was left on the floor and made comfortable and monitored until paramedics arrived. When interviewed on 3/12/26 at 1:43 p.m. the Executive Director indicated if a tenant had a fall with pain staff should not move the tenant unless the nurse says unless the tenant was insisting to get up, but generally no, if a tenant was in pain it would depend on what the nurse said.	A 160		
A 365	481-67.9(4)g Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 365		

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 03/12/2026

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

(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 365	Continued From page 16 Program failed to ensure certified and noncertified staff communicated in writing occurrences that differed from the tenants' normal health, functional and cognitive status. This pertained to 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Record review on 3/10/26 and 3/11/26 of Tenant C1's file revealed an incident report dated 9/19/25, indicated at 4:30 p.m. Staff A went to Tenant C1's apartment to wake her up for supper and Tenant C1 was non-responsive. Her vitals were taken, a blood pressure was not able to be obtained, her heart rate was 24 and oxygen saturation was 80 percent (%) and dropping. Staff was instructed to call 911 to transport Tenant C1 to the hospital. Tenant C1's power of attorney (POA) was notified and would meet her at the hospital. Continued record review revealed Progress Notes indicated the following: There were no entries in September prior to 9/16/25 nurse's notes. -On 9/16/26, Tenant C1 received the flu vaccine and it was well tolerated. -On 9/19/25, Staff A went to Tenant C1's apartment to wake her up for supper and Tenant C1 was non-responsive. Her vitals were taken, a blood pressure was not able to be obtained, her heart rate was 24 and oxygen saturation was 80% and dropping. Staff was instructed to call 911 to transport Tenant C1 to the hospital. Tenant C1's POA was notified and would meet her at the hospital.	A 365		

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 03/12/2026

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

(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 365	Continued From page 17	A 365		

-On 9/19/25, a report was given from the hospital indicating Tenant C1 was actively dying and was transferred to the unit for comfort care.

-On 9/19/25, a discussion was held with Tenant C1's POA and it was reported Tenant C1 was alert and at baseline.

-On 9/22/25, Tenant C1 returned from the hospital and there were new orders for hospice.

When interviewed on 3/12/26 at 9:03 a.m. Staff A reported the week prior (to the hospital) staff realized Tenant C1 was not standing up to transfer and would push staff away. She believed it was reported to the nurse.

When interviewed on 3/11/26 at 1:34 p.m. Staff D recalled she could only remember Tenant C1 was ill, very sick, maybe the flu or something. She did not remember if the nurse was contacted. Staff checked on her every hour.

When interviewed on 3/12/26 at 10:27 a.m. Staff E reported before Tenant C1 went on hospice she could not really stand anymore. Staff got Tenant C1 into a wheelchair with a gait belt and walker.

Continued record review revealed Tenant C1's service plan, dated 3/20/25, reflected the following cares were in place as of 9/19/25: staff administered her medications, she required total assistance with dressing, total assistance with toileting. Staff was to toilet Tenant C1 four times per shift. Tenant C1 was incontinent of bladder and bowel. The service plan indicated Tenant C1 had a history of UTIs and staff were to monitor for signs and symptoms including pain, frequency, urgency, burning, foul odor, incontinence, dizziness, weakness and confusion. Staff were to

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 03/12/2026

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

(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 365	Continued From page 18	A 365		

report changes to the nurse and if symptoms were noted to encourage fluids. Tenant C1 wore a protective undergarment. Tenant C1 required total assistance with eating and food cut into small pieces. Tenant C1 required assistance of one person with a gait belt and walker. She also required total assistance with grooming, hygiene and bathing. Tenant C1 required visual/safety checks eight times per shift.

Further record review on 3/11/25 of Tenant C1's hospital records indicated the Prehospital Care Report indicated at 4:35 p.m. the ambulance was dispatched to the Program. Upon arrival to the Program. Staff reported Tenant C1 had shortness of breath. Her oxygen saturation was 80 and declining and her pulse was 24 and was declining. Staff was asked if Tenant C1 had eaten anything today and staff responded she must have as the staff had to feed her. Tenant C1 was lying in bed. She was reported to be non-verbal (baseline). She was transported to the ambulance. Her vitals were taken and indicated: pulse was 72, respiratory rate was 14, blood pressure was 125/58. Oxygen saturation was 96 %. Hospital records indicated Tenant C1 was non-verbal, did not follow commands and did not assist with movement. Program staff could not state what her baseline was and they did not know the last time she ate or ambulated. They did not know if she talked or not as her baseline. "Patient has visible pus in her depends. Her urine is brown and purulent. Patient has a very potent foul odor from having soiled herself." It was unknown the last time she was seen well. "Based on patient's presentation with severe encephalopathy, presumed severe sepsis from urinary tract infection." The records indicated the assessment/plan was acute metabolic encephalopathy (likely secondary to sepsis from

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 03/12/2026

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

(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 365	Continued From page 19	A 365		

UTI, admission for end-of-life care, acute cystitis with hematuria, bradycardia and hypoxia. It was noted "Complicated UTI" and "Severe dehydration." The plan was to be discharged back to the Program on Monday with hospice care. Tenant C1 fingers/hands "noted to be contracted et mottled, depends heavily soiled et foul smelling with puss (sic) visualized, puss (sic)/thick brown-red urine also noted with catheterization, vague report received from care center et unknown last known well et unknown last time she ate or had PO interventions."

Continued record review revealed there were no staff to nurse communication sheets for Tenant C1 during that time frame or in the three months prior to her discharge. There were also no nurse's notes completed between 9/16/25 (when she received her flu shot) until the incident report note on 9/19/25 when Tenant C1 was found non-responsive.

2. Record review on 3/10/26 to 3/12/26 of Tenant C2's file revealed Progress Notes indicated the following:

-On 9/14/25 at 7:47 a.m., staff called and reported Tenant C2 had an elevated temperature and congestion. Her oxygen saturation was 91% and temperature was 100.6 degrees. Tenant C2 POA was notified and requested transport to the ED.

-On 9/14/25 at 1:30 p.m., staff called to report an unwitnessed fall. Tenant C2 went to pick up her tray and fell. No head strike was reported but her pain in the left hip was 10/10. Tenant C2 had just returned from the hospital where she was told she had a virus.

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 03/12/2026

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

(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 365	Continued From page 20	A 365		

-On 9/15/25, a nurse followed up with hospital staff and was told Tenant C2 was currently in surgery for the left fractured hip.

-On 9/16/25, a nurse followed up with hospital staff and was told Tenant C2 had no pain, started to work with therapy and walked with the assistance of one person and a walker. Tenant C2 had tested positive for COVID-19 prior to surgery.

When interviewed on 3/12/26 at 10:18 a.m. Staff G indicated she worked on third shift (third shift before her fall) and Tenant C2 was not feeling well. Tenant C2 had congestion and cold symptoms. Staff G told the oncoming shift about Tenant C2's illness at shift report.

When interviewed on 3/12/26 at 9:03 a.m. Staff A indicated third shift reported Tenant C2 felt fine but was coughing. Tenant C2 felt hot but her temperature was not elevated per third shift staff. Staff A went to Tenant C2's apartment, Tenant C2 had a raspy voice and felt fine but had a very elevated temperature. Staff A called triage and Tenant C2 was sent out to the hospital.

Further record review revealed hospital records (hospital #1) from the ED visit on 9/14/25 indicated Tenant C2, who had a history of dementia, came to the ED after having a fever. It was noted her vital signs were stable, she was afebrile and received an antipyretic. The white blood cell count was normal. The chest x-ray showed no acute cardiopulmonary processes. It was noted most likely it was viral. In the hospital records it indicated two attempts were made to call a report to the Program without success, there was no answer. She was discharged back to the Program. She was told to follow up with her

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 03/12/2026

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

(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 365	Continued From page 21 provider in one to two days and to return to the ED if anything changed or worsened. Continued record review revealed there were no staff to nurse communication sheets for Tenant C2 during that time frame or in the three months prior to her discharge. When interviewed on 3/12/26 at 1:43 p.m. the Executive Director confirmed there were no staff to nurse documentation sheets for any of the tenants reviewed (including Tenant C1 and Tenant C2).	A 365		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed and failed to develop service plans that reflected the service needs of tenants. This pertained to 2 of 2 current tenants reviewed (Tenant #1 and Tenant #2) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow:	A 350		

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 03/12/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 22 1. Record review on 3/11/26 of Tenant #1's file revealed Progress Notes revealed the following: -On 3/06/26, a new order was received for Nystatin-Triamcinolone 100000-0.1 unit/gram external cream. Apply to the vaginal area up to four times daily. -On 3/09/26, blisters/papules were observed to Tenant #1's vaginal area, especially on the right side. Tenant #1 reported the skin issue for a length of time. It appeared to be related to irritation from protective undergarment with pad insert. Education was provided to Tenant #1 on perineal care, changing pad/protective undergarment when it was wet. The order (above) was for Nystatin four times per day as needed and staff would offer to put the cream on throughout the day. Continued record review revealed Tenant #1's service plan, dated 2/06/26 reflected Tenant #1 required extensive assistance with toileting, required physical assistance with parts of toileting tasks, was incontinent of bladder and wore protective undergarments. The service plan reflected staff administered Tenant #1's medications. Further record review revealed Tenant #1's service plan failed to reflect the skin integrity issue of the blisters/papules as noted above or the treatment ordered related to the skin issue. When interviewed on 3/12/26 at 1: 43 p.m. the Executive Director confirmed all service plans were provided for the tenant. Regarding Tenant #1's service plan she did not see the skin issue on the service plan but needed to check through	A 350		

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 03/12/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 23 emails to see if another service plan had been emailed. 2. Record review on 3/11/26 of Tenant #2's file revealed Progress Notes indicated the following: -On 2/06/26, Tenant #2 continued to live in assisted living with his spouse and he did very well. He was not an elopement risk. -On 2/24/26, Tenant #2 was admitted to hospice with diagnoses of Alzheimer's disease and COVID-19. -On 2/27/26, Tenant #2 moved to memory care that morning. Continued record review revealed Tenant #2's service plan, dated 2/24/26 reflected staff completed additional visual/safety checks during the day so his spouse could do other things. It started at 9:00 a.m. to 5:00 p.m. Tenant #2 and his spouse would return to their apartment after supper every evening. Further record review revealed Tenant #2's service plan failed to be updated when Tenant #2 moved to memory care, no longer resided with his spouse and to reflect the current visual/safety checks. When interviewed on 3/12/26 at 1: 43 p.m. the Executive Director confirmed all service plans were provided for the tenant. Regarding Tenant #2's service plan on page 8 it reflected he was in memory care and said his spouse still visited him in memory care. She confirmed checks were completed in memory care at least hourly and were completed 24/7.	A 350		

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 03/12/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 24 3. Record review on 3/10/26 and 3/11/26 of Tenant C1's file revealed an incident report, dated 9/19/25, indicated at 4:30 p.m. Staff A went to Tenant C1's apartment to wake her up for supper and Tenant C1 was non-responsive. Her vitals were taken, a blood pressure was not able to be obtained, her heart rate was 24 and oxygen saturation was 80% and dropping. Staff was instructed to call 911 to transport Tenant C1 to the hospital. Tenant C1's power of attorney (POA) was notified and would meet her at the hospital. Continued record review revealed Progress Notes indicated the following: -9/16/26, Tenant C1 received the flu vaccine and it was well tolerated. -On 9/19/25, Staff A went to Tenant C1's apartment to wake her up for supper and Tenant C1 was non-responsive. Vitals were taken, a blood pressure was not able to be obtained, heart rate was 24 and her oxygen saturation was 80% and dropping. Staff was instructed to call 911 to transport Tenant C1 to the hospital. Tenant C1's POA was notified and would meet her at the hospital. -On 9/19/25, a report was given from the hospital indicating Tenant C1 was actively dying and was transferred to the unit for comfort care. -On 9/19/25, a discussion was held with Tenant C1's POA and it was reported Tenant C1 was alert and at baseline. -On 9/22/25, Tenant C1 returned from the hospital and there were new orders for hospice.	A 350		

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 03/12/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 25 -On 9/23/25, Tenant C1 was alert, awake and non-verbal. Tenant C1 was bed bound. -On 9/30/25, hospice visited today and Tenant C1 had cool extremities with some mottling. Tenant C1 continued to pocket food and ate a small amount of soft food. -On 10/02/25, Tenant C1 was unable to swallow her medications, applesauce or water. -On 10/02/25, all oral medications were discontinued. Lorazepam and morphine were started. -On 10/03/25, Tenant C1 died. Continued record review revealed Tenant C1's service plan, dated 9/22/25 failed to reflect soft foods and pocketing of foods. The service plan also failed to reflect the discontinuation of oral medications and difficulty swallowing medications. When interviewed on 3/12/26 at 1:43 p.m. the Executive Director confirmed all service plans were provided for the tenant. 4. Record review on 3/10/26 to 3/12/26 of Tenant C2's file revealed Progress Notes indicated the following: -On 8/28/25 it was noted on 8/27/25 at 8:15 a.m. Tenant C2 was ready for the day, was up to walk to the bathroom. Staff folded her blankets with the staff's back to Tenant C2 and heard a noise. Staff observed Tenant C2 laying on the left side in the bathroom and she was bleeding from the forehead. Pressure was applied, the nurse was notified and 911 was called for transport to the	A 350		

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 03/12/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 26	A 350		

hospital.

-On 8/28/25, Tenant C2 was seen by the nurse practitioner (NP) today. The laceration looked good and the splint/cast remained on the left hand.

-On 8/29/25, the wound to the left forehead was assessed and the dressing was changed. The wound was clean, dry, no redness, no drainage or warmth noted.

-On 8/29/25, the 90-day assessment and change of condition assessment were completed.

Continued record review revealed a NP Progress Notes (visit note) with a date of service of 8/28/25 indicated Tenant C2 fell in her bathroom on 8/27/25 and a staff was in the room with her. Tenant C2 walked independently in her apartment. Staff was picking up her sleeping area, folding a blanket and heard her fall in the bathroom. She was lying on her left side. Tenant C2 sustained a large laceration to the left forehead and a left-hand fracture. Tenant C2 had a brace, "plaster type splint" on her left hand. It noted sutures would be removed in one week. A follow up appointment was scheduled for 9/19/25 with an orthopedic surgeon.

When interviewed on 3/12/26 at 9:03 a.m. Staff A reported Tenant C2 had a left-hand splint. She could not recall what occurred with bathing but said at first Tenant C2 struggled with eating. Staff assisted and guided Tenant C2's other hand (related to eating).

When interviewed on 3/12/26 at 11:23 a.m. Staff B indicated when Tenant C2 had a motion alarm, it was a chair or floor alarm. It was audible and

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 03/12/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 350	Continued From page 27 made a loud noise when she moved about. When interviewed on 3/12/26 at 10:27 a.m. Staff E reported Tenant C2 had a sensor alarm that detected movement, it was new after Tenant C2's splint. It was a loud alarm but was not attached to the tablet. Staff had to put a towel around it (splint) for bathing and everyone had to be careful. Further record review revealed Tenant C2's service plan, dated 8/29/25, indicated (8/27/25) staff would encourage Tenant C2 to walk carefully first thing in the morning. The service plan reflected Tenant C2 was independent with eating, she required minimal assistance with dressing and required assistance with bathing. The service plan failed to be updated for the splint/cast with instructions for bathing to ensure the cast/splint remained dry and any extra assistance needed. The service plan also failed to reflect assistance with eating related to the split/cast or dressing assistance related to the cast/splint. The service plan failed to reflect the personal alarm used related to Tenant C2's falls. When interviewed on 3/12/26 at 1: 43 p.m. the Executive Director confirmed all service plans were provided for the tenants reviewed. She said when asked if the service plan had bathing and eating related to Tenant C2's splint/cast, that it had wound care as prescribed. She confirmed it did not have the alarm on the service plan.	A 350		
A 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse	A 430		

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 03/12/2026

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

(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 430	Continued From page 28	A 430		

review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse:

c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status;

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the Program failed to complete nurse reviews as needed. This pertained to 1 of 2 discharged tenants reviewed (Tenant C2). Finding follows:

Record review on 3/10/26 to 3/12/26 of Tenant C2's file revealed Progress Notes indicated the following:

-On 8/28/25 it was noted on 8/27/25 at 8:15 a.m. Tenant C2 was ready for the day and up to walk to the bathroom. Staff folded her blankets with the staff's back to Tenant C2 and heard a noise. Staff observed Tenant C2 laying on the left side in the bathroom and she was bleeding from the forehead. Pressure was applied, the nurse was notified and 911 was called for transport to the hospital.

-On 8/28/25, Tenant C2 was seen by the nurse practitioner (NP) today. The laceration looked good and the splint/cast remained on the left hand.

-On 8/29/25, the wound to the left forehead was assessed and the dressing was changed. The wound was clean, dry, no redness, no drainage or

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 03/12/2026

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

(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 430	Continued From page 29	A 430		

warmth noted.

-On 8/29/25, the 90-day assessment and change of condition assessment were completed.

Continued record review revealed hospital discharge summary provided by the Program (fax dated 3/11/26 to the Program) indicated Tenant C2 presented with a left forehead laceration after a fall. After Tenant C2 was getting a shower, she tripped and fell on the floor. It was noted an eight-centimeter (cm) laceration of the left frontal scalp. The left dorsal hand ulnar aspect had localized swelling, bruising and was tender. The x-ray of the left hand revealed a nondisplaced 4th and 5th metacarpal fracture. An Orthro-Glass splint was applied to the left hand. Discharge instructions indicated to return to the emergency department (ED) in one week for suture removal, follow up with orthopedics in one to two weeks and follow up with Tenant C2's provider in one to two weeks. The discharge instructions were not noted with time, date or signature and were not received by the Program until 3/11/26 (incident on 8/27/25).

Further record review revealed a NP Progress Notes (visit note) with a date of service of 8/28/25 indicated Tenant C2 fell in her bathroom on 8/27/25 and a staff was in the room with her. Tenant C2 walked independently in her apartment. Staff was picking up her sleeping area, folding a blanket and heard her fall in the bathroom. She was lying on her left side. Tenant C2 sustained a large laceration to the left forehead and had a left-hand fracture. Tenant C2 had a brace, "plaster type splint" on her left hand. It noted sutures would be removed in one week. A follow up appointment was scheduled for 9/19/25 with an orthopedic surgeon.

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 03/12/2026

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

(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 430	Continued From page 30 Continued record review revealed a nurse review failed to be completed related to Tenant C2's suture removal, follow up on the laceration (after 8/29/25) to ensure the sutures were intact and no signs of infection, notation of the discharge instructions from the ED and to follow up on the hand splint and circulation (after 8/28/25). A nurse review was not completed as needed related to Tenant C2's laceration and hand fracture with splint. When interviewed on 3/12/26 at 1:43 p.m. the Executive Director indicated all nurse reviews and nurse notes were provided for the tenant. The Executive Director confirmed she did not see it in the notes (related to the removal of the sutures). She indicated the family did not give the Program the discharge summary (from the ED).	A 430		