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
	S0017	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR MEMORY CARE	900 W 46TH ST DAVENPORT, IA 52806

(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: 0 Tenants with cognitive impairment: 31 Total census: 31 The following regulatory insufficiencies were cited during the investigation of Complaint #130478-C, Complaint #131093-C and Complaint #131499-C.	A 000	See attached POC 7/10/26	
A 122	481-67.3(2) Tenant Rights 481-67.3(231B,231C,231D) Tenant rights. All tenants have the following rights: 67.3(2)?To receive care, treatment and services that are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide appropriate services 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 include but are not limited to: 1) Record review on 5/12/26 of a Service Plan dated 2/5/26 for Tenant #1 identified he was incontinent of bladder and bowel. He required reminders for toileting and the changing of his clothing and incontinence brief. He needed help to clean up after his brief or clothing was soiled. Tenant #1 required assistance in setting up the	A 122		

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shower such as adjusting the water to the right temperature and ensuring he had the proper hygiene products. He was independent after the shower was started and the room was set up. Staff were to monitor his skin when he was getting ready for the shower. Tenant #1 required reminders for changing his clothing and incontinence brief daily. They were to make sure he was wearing shoes. Staff were to provide weekly housekeeping and make his bed each morning. They were to wash his clothing and linen weekly and as needed.

A May, 2026 task sheet dated 5/1 - 5/10 revealed the following:
- Staff were directed to assist Tenant #1 with bathing as needed. No one documented providing him with a bath.
- He was to receive assistance with dressing each twelve hour shift (twice daily). Staff documented helping him once daily on six days.
- Tenant #1 was to receive standby assistance with toileting every shift (nothing about reminders). He received help twice a shift on six days.
- Staff were directed to wash linens and laundry and make the bed as needed. No one charted on these tasks. Housekeeping was not on the task sheet.

2) Tenant #2 had a Service Plan dated 4/27/26 which noted she was incontinent of bladder and bowel and had difficulty communicating her needs. Staff needed to assist her with getting to and from the toilet (no frequency listed). She needed help with transferring in and out of the shower, shampooing her hair and washing herself (no frequency listed). Tenant #2 required assistance picking out clothing, dressing her upper and lower body and getting undressed at

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the end of the day. Staff were to cut up her foods and provide hand over hand feeding if needed. She needed twice daily assistance with hygiene tasks. Staff were to provide assistance with washing her clothing and linens each Saturday. Her apartment should be cleaned weekly.

Review of a May, 2026 task sheet for Tenant #2 dated 5/1 - 5/10 revealed the following:
- Staff were to assist her with toileting every shift (once every 12 hours). Staff only assisted her to the toilet once during the days of 5/2, 5/4, 5/8 and 5/9.
- Tenant #2 was to receive assistance with bathing each Saturday and Wednesday. She received one bath on 5/6.
- Staff documented helping Tenant #2 with dressing on 6 days out of 10. Of the six days staff noted helping her with dressing, the assistance was provided once during the shift rather than twice.
- Staff were to document helping her with eating three times a day. They noted helping her with breakfast 7 of 10 days, at lunch 7 of 10 days and 6 of 10 days at dinner.
- She received staff assistance with hygiene tasks twice daily on 6 days out of 10.
- Staff documented washing her laundry on 5/3/26 and 5/10/26. No one changed her linens or documented cleaning her apartment.

3) Tenant C1 had a Service Plan dated 10/24/25 which identified staff were to check on him twelve times a shift. He required assistance with dressing and undressing. On days he did not get out of bed, staff needed to provide complete assistance with this task. Tenant C1 needed standby assistance with toileting. He required setup for hair care, face washing and oral care. On days he did not get out of bed he would be

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washed up by staff. They were to assist him with laundry (no frequency listed). He required weekly assistance with cleaning.

A review of a Nov. 2025 task sheet for Tenant C1 dated 11/1 - 11/10 revealed the following:
- Staff were to provide safety checks every shift. They failed to provide safety checks twice daily 3 days out of 10.
- The task sheet noted Tenant C1 required assistance with dressing every shift. He did not receive assistance 3 days out of 10.
- The task sheet noted Tenant C1 required assistance with toileting every shift but did not explain how frequently staff should provide this help. Staff documented providing assistance each shift on 7 of 10 days and only one shift on 3 of 10 days.
- Personal hygiene was not provided on 3 of 10 days.
- There was no documentation of staff completing laundry or housekeeping for Tenant C1.
- Bed making was on Tenant C1's task sheet. Staff performed this task 7 of 10 days.

4) Tenant C2 had a Service Plan dated 10/8/25 which noted she was incontinent of bowel and bladder. She required the use of the toilet every 2 hours while awake and once in the middle of the night. Tenant C2 required safety checks 12 times a shift. Staff were to assist her with showering (no frequency noted). Tenant C2 required staff assistance with housekeeping and laundry twice weekly and as needed. Staff should remove her garbage each shift and make her bed daily.

A review of a Nov. 2025 task sheet for Tenant C2 dated 11/1 - 11/10 revealed the following:
- Staff were to help her with toileting every shift

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A 122	Continued From page 4 (not every 2 hours). Staff documented assisting her on one shift over five days. - Staff provided safety checks to Tenant C2 each shift on 6 days and only 1 shift on 4 days. - There was no documentation staff assisted her with housekeeping, bathing, laundry, linens or trash removal. All these tasks were marked PRN or "as needed". During an interview with the Director of Wellness on 5/12/26 at 1:10 PM she reported the tasks she put in as PRN should have been scheduled. The Director of Wellness confirmed staff weren't good about documenting the completion of tasks but believed the tasks were being completed. She confirmed the tasks sheets reflected tenants were not receiving the services identified in their service plans.	A 122		
A 151	481-67.5(2)e(2) Medications 481-67.5(231B,231C,231D) Medications. 67.5(2)?Each program shall follow its own written medication policy, including the following: e. When medications are administered traditionally by the program: (2) The program will maintain a list of each tenant's medications and document the medications administered. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff accurately documented the administration of medication for 1 of 2 current tenants reviewed (Tenant #1).	A 151		

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Findings follow:

1) Record review on 5/11/26 of a Service Plan dated 2/5/26 revealed Tenant #1 received medication management from the Program. He required assistance with medication administration, ordering medication and communicating with the pharmacy. This service was initiated on 2/5/25.

A review of the Medication Administration Record documenting wound care performed for Tenant #1 from October, 2025 - March, 2026 revealed the following:
- No refusals of wound care in October, 2025.
- 1 refusal of wound care on 11/15/25 for November, 2025.
- No refusals of wound care in December, 2025.
- No refusals of wound care in January, 2026.
- 1 refusal of wound care on 2/25/26 for February, 2026.
- 1 refusal of wound care on 3/25/26 for March, 2026.

During an interview with Staff A on 5/12/26 at 1:35 PM she reported Tenant #1 refused his wound care frequently. She would often document she performed the wound care and if he refused she would forget to go back and correct this in the electronic record. Staff A stated Tenant #1 did not only refuse wound care for her but for everyone. She would reapproach him but he would continue to refuse the service.

Staff B was interviewed on 5/11/26 at 4:10 PM and reported Tenant #1 allowed her to perform his wound care but did not allow others to do so. There were times she would write the date on his dressings and when she returned to work the same days later the bandage would be on his

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wound when it should have been changed. Tenant #1's wound care was a major concern for her.

The Director of Wellness reported on 5/11/26 at 11:50 AM she reviewed the MARs and saw staff documented Tenant #1 received wound care although they reported to her he often refused it.

2) Record review on 5/11/26 of Tenant #1's MARs from October, 2025 - March, 2026 revealed he received wound care throughout these months. The Program provided physician's orders from the wound care clinic dated 12/9/25, 1/16/26, 1/13/26, 3/3/26 and 3/10/26. He discharged from the wound care clinic on 3/24/26.

The Program requested additional records from the Wound Care Clinic on 5/12/26. Upon receipt of these records it was discovered the tenant also received treatment and potential order changes on: 10/14/25, 10/21/25, 11/4/25, 11/11/25, 11/25/25, 12/16/25, 12/23/25 and 2/24/26. The Program failed to maintain an accurate list of Tenant #1's prescribed dressings and medications as follows:

10/14/25: Incorrect orders for Wound #20, dressing should be changed three times per week, not daily
No orders for Wound #21 Left, Distal Second Toe: band aid as needed to keep from rubbing.
No orders for Wound #22 Proximal, Lateral Fifth Toe: Primary dressing: Silver Alginate, Secondary Dressing: Roll Gauze, change dressing three times per week (it was healed on 11/4/25).

12/23/25: Wound #23 Right Foot: Primary dressing: Silver Alginate, Secondary Dressing: roll gauze, gauze 4 x 4 three times a week and as

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A 151	Continued From page 7 needed (this order was never added to the MAR). 1/6/26: Wound #24 Left, Dorsal Great Toe: Primary dressing: Silver Alginate, Secondary dressing: Optifoam in between great toe and second toe, roll gauze and tape. Change dressing three times per week (this order was never added to the MAR). 1/13/26: The orders for the secondary dressing for Wound #21 were updated on 1/13/26. The roll gauze was replaced with optifoam or a hydrophilic foam. This change was not made on the MAR. During an exit meeting conducted with the Executive Director and Director of Wellness on 5/13/26 at 11:45 AM they confirmed the Program failed to ensure they maintained a current list of Tenant #1's medication. They also failed to ensure staff accurately documented the medication they administered to tenants.	A 151		
A 152	481-67.5(2)e(3) Medications 481-67.5(231B,231C,231D) Medications. 67.5(2)?Each program shall follow its own written medication policy, including the following: e. When medications are administered traditionally by the program: (3) Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or PA.	A 152		

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A 152	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure medication and treatments were administered as prescribed to 1 of 2 current tenants reviewed (Tenant #1). Findings follow: Record review on 5/11/26 of a Service Plan for Tenant #1 dated 2/5/26 revealed he required assistance with medication administration, the ordering of medication, communication with the pharmacy and completing lab orders. This would be completed by the Certified Medical Assistants (CMAs), Nurse Manager, Director of Wellness and Wellness Coordinator. The task was initiated on 2/5/25. He also required wound treatment which would be completed by trained staff (CMAs, Director of Wellness) three times a week. The wound clinic would monitor and change dressings at appointments as well. 1) A review of Tenant #1's MARs from October, 2025 - March, 2026 revealed he received wound care throughout these months. The Program provided physician's orders from the Wound Care Clinic (WCC) dated 12/9/25, 1/16/26, 1/13/26, 3/3/26 and 3/10/26. He discharged from the wound care clinic on 3/24/26. The Program requested additional records from the WCC on 5/12/26. Upon receipt of these records it was discovered Tenant #1 also received treatment and potential order changes on: 10/14/25, 10/21/25, 11/4/25, 11/11/25, 11/25/25, 12/16/25, 12/23/25 and 2/24/26. The Program failed to complete wound care as ordered for Tenant #1 as follows: Tenant #1 was seen at the WCC on 10/14/25 and	A 152		

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received orders for treatment of Wound #20, to his Lateral Fifth toe. The Program provided him with the correct dressing, but the orders on the MAR directed staff to change the dressing daily while the physician ordered the dressing to be changed three times per week. The Program did not add an order to the MAR for Wound #21 to the Left, Distal Second Toe: band aid as needed to keep from rubbing. There were also no orders for Wound #22 to the Proximal, Lateral Fifth Toe: Primary dressing: Silver Alginate, Secondary dressing: roll gauze, change dressing three times per week (it was healed on 11/4/25).

The WCC continued to provide the same orders for Tenant #1 to receive wound care to Wound #21 (Left, Distal Second Toe) on 10/21/25, 11/4/25, 11/11/25, 11/25/25 and 12/9/25 and 12/16/25. On 12/9/25, Tenant #1 developed a wound on his Right Foot, Wound #23 which staff were to treat with a Primary dressing of Puracol and a Secondary dressing of 4 x 4 gauze. The Program failed to provide treatment to Tenant #1's Left, Distal Second Toe or Right Foot until 12/24/25.

A note from the WCC dated 12/16/25 identified Tenant #1 was sent to the Emergency Room (ER) due to elevated blood sugar readings of 343, weakness, shortness of breath and an elevated pulse rate. The hospital Discharge Summary dated 12/19/25 identified while at the ER Tenant #1 was diagnosed by podiatry with osteomyelitis of the left foot and offered amputation but he refused. He grew Staph epidermin in 1 of 2 bottles and infectious disease was consulted. They did not think the osteomyelitis needed any long-term antibiotic. Upon discharge he was diagnosed with Acute osteomyelitis of the left foot and at-risk for sepsis. He was instructed to apply

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a single layer of Xeroform and Silicone Foam or a bandaid daily to the Right Foot (#23), Left 2nd toe (#21) and Left 5th toe (#20).

A review of the December, 2025 MAR identified the Program did not implement the hospital wound orders at the time of discharge. The Program did institute the orders from the WCC dated 12/16/25 for Wound #21 and Wound #23 on 12/24/25. Tenant #1 returned to the WCC on 1/6/26. The WCC updated the orders for Wound #21 to: Primary dressing: Silver Alginate, Secondary dressing: Optifoam or other Hydrophilic foam in between great toe and 2nd toe, roll gauze and tape, change dressing three times per week. The Program failed to include the Secondary dressing on the MAR. The WCC had orders for Tenant #1's Right Foot (Wound #23) for a Primary dressing: Silver Alginate and a Secondary dressing: roll gauze, gauze 4 x 4, change dressing three times per week. The Program did not update the wound care orders. Tenant #1 also received orders to Wound #24 on his Left Dorsal Great Toe. The Program did not add these to the MAR.

Tenant #1 presented at the ER on 1/18/26 with his left, lower extremity hot and red from the lower to upper lateral shin which was consistent with strep cellulitis. Given his history of MRSA colonization, empiric Vancomycin and Zosyn were initiated (two powerful, broad-spectrum antibiotics often given together to acutely ill hospitalized patients). He was initially switched to Bactrim, but developed an acute kidney injury so was switched to Doxycyline. A plan was made for suppressive Doxycyline 100 mg. by mouth once daily after discharge. An x-ray was ordered and an area of concern was noted which correlated with dry gangrene of the Left 2nd toe, there was

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osteomyelitis of the Left 5th Toe. On 1/30/26 Tenant #1 underwent a Left 2nd toe amputation. Upon discharge, the Program was ordered to provide wound care to the Right Foot, Left 2nd toe and Left 5th toe of a single layer of Xeroform and Silicone foam or a bandaid. Tenant #1 received this treatment to his Left 2nd toe. The Program did not follow these orders when treating his Right Foot or Left 5th toe, although they did treat the wounds with an alternate dressing.

His home Lasix and Lisinopril were held while inpatient due to infection and surgery without issue so they were discontinued upon discharge. His Potassium Chloride was also discontinued. A review of the February, 2026 MAR revealed the Program failed to discontinue Tenant #1's Lasix, Lisinopril or Potassium Chloride when he returned. Tenant #1 was prescribed Doxycycline upon discharge but the Program did not administer the medication.

During interviews with the Director of Wellness (DOW) on 5/12/26 at 11:50 AM and 5/13/26 at 11:25 AM she reported she often did not receive orders from the WCC. She might receive a baggie with dressings when he returned from the WCC but did not know how to apply them. The DOW told Tenant #1's daughter she needed orders from the WCC or she had to stick with the treatment she was providing. When she did receive the orders she made the changes to the MAR. The DOW believed the delay in putting in the 12/9/25 order was related to not having the dressings, but she did not have documentation of this. She did not receive the Xeroform when Tenant #1 discharged from the hospital on 12/20/25 which was why she did not put this order into the MAR. On 5/18/26 at 2:30 PM the DOW stated she did not catch the medication changes

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A 152	Continued From page 12 when Tenant #1 discharged from the hospital on 2/4/26 as the orders were sent directly to the pharmacy. Tenant #1's daughter was interviewed on 5/13/26 at 7:45 AM and stated each time she took her father to an appointment at the WCC she would receive a copy of the physician's orders and provide a copy to the DOW. She put the orders under the DOW's door as well as dressings he received from the clinic. On 5/13/26 at 8:10 AM a nurse from the WCC reported the physician's orders were sent to the Program following each appointment Tenant #1 attended. If the DOW had questions she could have called as there was a nurse's line and all calls were responded to daily. During an exit meeting conducted with the Executive Director and DOW on 5/13/26 at 11:45 AM they confirmed the Program failed to ensure Tenant #1 received his medication and treatments as ordered by his medical providers.	A 152		
A 232	481-69.22(3) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation.	A 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0017	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR MEMORY CARE	900 W 46TH ST DAVENPORT, IA 52806

(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 232	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to reassess the needs of 1 of 2 current tenants reviewed when he returned from the hospital (Tenant #1). Findings follow: Record review on 5/13/26 of a Discharge Summary dated 12/19/25 identified he presented to the hospital with complaints of shortness of breath and left foot acute worsening of chronic pain. He was evaluated by the podiatrist and diagnosed with acute osteomyelitis of the left foot (an infection and inflammation of the bone, primarily caused by bacteria or fungi, which could occur when germs spread through the bloodstream and enter via a nearby open wound). He was offered amputation but refused this. He grew Staph epidermin in 1 out of 2 bottles and infectious disease was consulted. They did not think the osteomyelitis needed any long-term antibiotics were needed as repeated blood cultures were negative. Tenant #1 was discharged with diagnoses of acute osteomyeletis of the left foot and at-risk for sepsis. He was given instructions for wound care. Tenant #1 was to follow up with the wound clinic and cardiology. Further record review failed to reveal evaluations follow change in condition. During an interview with the Director of Wellness on 5/12/26 at 4:10 PM she confirmed the Program failed to fully evaluate Tenant #1's needs when he returned from the hospital following his hospitalization on 12/19/25.	A 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 268	Continued From page 14	A 268		
A 268	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program nurse failed to document nurses' notes by exception following emergency room visits for 1 of 2 current tenants reviewed (Tenant #1). Findings follow: Record review on 5/11/26 revealed an Emergency Room (ER) Physician Note dated 3/10/26 in which Tenant #1 was at the wound clinic and became short of breath. He had chest pressure which started in the morning. He was sent to the ER. On 3/26/26 an ER Physician Note indicated Tenant #1 presented due to shortness of breath. He did not have pain or fever but generalized illness. A review of Progress Notes revealed no information about Tenant #1's visits to the ER on 3/10/26 or 3/26/26.	A 268		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 268	Continued From page 15 During an exit meeting conducted on 5/13/26 at 11:45 AM the Director of Wellness confirmed she failed to document Tenant #1's emergency room visits in the electronic record.	A 268		
A 285	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and indicate: a. The tenant's identified needs and preferences for assistance; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to include the needs of 1 of 2 current tenants reviewed on a service plan (Tenant #1). Findings follow: Record review on 5/12/26 of Discharge Instructions from the Wound Clinic dated 12/9/25 for Tenant #1 revealed he had wounds to his Left Lateral 5th Toe, Left Distal 2nd Toe and Right Foot. He was not to get shower or bath water on his wounds. He should keep his wounds covered and dry when bathing. He could use saran wrap to cover his dressings. It was also recommended he increase protein in his diet to promote wound healing. He should elevate his legs above the level of his heart when sitting to decrease swelling. These recommendations were repeated in the physician's orders the Program had dated 1/6/26 and 1/13/26. Tenant #1 was hospitalized on 1/18/26 and discharged on 2/2/26. The Program	A 285		

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A 285	Continued From page 16 did not have orders from the Wound Clinic until 3/3/26 at which time he was still encouraged to have protein in his diet and elevate his legs, but keeping his wounds covered was not addressed. Tenant #1 had service plans dated 12/8/25, 12/22/25 and 2/5/26. In all service plans it was noted staff were to observe his skin on shower days. There was no mention of keeping his wounds covered. The plan did not encourage staff to have Tenant #1 elevate his legs or add protein to his diet. During a meeting with the Director of Wellness on 5/12/26 at 4:10 PM she confirmed the Program failed to include Tenant #1's needs on his service plan.	A 285		
A 291	481-69.27(2)a Nurse Review 481-69.27(231C) Nurse review. 69.27(2) If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders;	A 291		

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A 291	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure prescription medication orders were correct following a significant change for 1 of 2 current tenants reviewed (Tenant #1). Findings follow: 1) Record review on 5/11/26 revealed an Order Summary Report for Tenant #1 dated 2/5/25 noting he should receive Novolin R Flexpen 100 unit/1ML, inject 18 units three times daily with meals, hold if glucose was below 140. The Director of Wellness noted she clarified all orders with Tenant #1's Primary Care Provider (PCP). A review of a Blood Sugar Graph dated 8/1/25 - 8/31/25 revealed staff tested Tenant #1's glucose levels 1-3 times a day throughout the month. A review of a Blood Sugar Graph dated 9/1/25 - 10/31/25 revealed staff tested Tenant #1's glucose level on 9/1/25 and 9/10/25 (twice). A review of a Blood Sugar Graph dated 11/1/25 - 12/31/25 revealed staff did not test his blood glucose from 11/1/25 - 12/19/25. They tested his blood glucose levels 1-2 times a day from 12/20/25 - 12/30/25. A Senior Living Level of Care and Service Plan Assessment was completed on 9/9/25 for Tenant #1 noting he should receive Blood Sugar Checks three times daily. Tenant #1's PCP met with him at the Program. The Program incorporated the PCP's notes into their Progress notes. The PCP notes dated 9/11/25, 9/30/25 and 11/18/25 all included information under the medication list: use blood-glucose meter as directed four times a day, use blood glucose test strip, use 1 strip via meter	A 291		

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A 291	Continued From page 18	A 291		

four times a day and use 1 lancet as directed four times a day.

The Director of Wellness (DOW) contacted the PCP on 12/12/25 and asked for an order to test Tenant #1's blood glucose twice daily. The PCP provided her with this order and staff began testing his blood glucose on 12/20/25.

The DOW was interviewed on 5/11/26 at 2:10 PM and explained when Tenant #1 returned to the building following a hospitalization the discharge paperwork did not include an order for him to have his blood sugar checked so the Program quit doing this. She was not aware the PCP continued to direct staff to check his blood glucose four times daily as she did not see this in his notes.

2) Tenant #1 presented at the ER on 1/18/26 with his left, lower extremity hot and red from the lower to upper lateral shin which was consistent with strep cellulitis. Given his history of MRSA colonization, empiric Vancomycin and Zosyn were initiated (two powerful, broad-spectrum antibiotics often given together to acutely ill hospitalized patients). He was initially switched to Bactrim, but developed an acute kidney injury so was switched to Doxycycline. A plan was made for suppressive Doxycycline 100 mg. by mouth once daily after discharge. An x-ray was ordered and an area of concern was noted which correlated with dry gangrene of the Left 2nd toe, there was osteomyelitis of the Left 5th Toe. On 1/30/26 Tenant #1 underwent a Left 2nd toe amputation. His home Lasix and Lisinopril were held while inpatient due to infection and surgery without issue so they were discontinued upon discharge. His Potassium Chloride was also discontinued. A review of the February, 2026 MAR revealed the

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A 291	Continued From page 19 Program failed to discontinue Tenant #1's Lasix, Lisinopril or Potassium Chloride when he returned. Tenant #1 was prescribed Doxycycline upon discharge but the Program did not administer the medication. During an interview with the DOW on 5/18/26 at 2:30 PM the DOW stated she did not catch the medication changes when Tenant #1 discharged from the hospital on 2/4/26 as the orders were sent directly to the pharmacy.	A 291		

Country Manor Memory Care
Statement of Deficiencies and Plan of Correction
Survey Completed: 05/18/2026
Printed: 06/11/2026
Provider Number: S0017
Provider Address: 900 W. 46th St., Davenport, IA 52806

Disclaimer: This Plan of Correction is submitted as the Program's written plan to achieve and maintain compliance. Submission of this Plan of Correction does not constitute an admission of wrongdoing, liability, or agreement with all findings, but reflects the Program's commitment to correcting the cited regulatory insufficiencies and strengthening systems for tenant care, services, documentation, medication management, and nurse review.

A122 — 481-67.3(2) Tenant Rights

Requirement: Tenants have the right to receive care, treatment, and services that are adequate and appropriate.

Corrective Action for Identified Tenants:
The Director of Wellness/designee completed a review of the current service plans and task documentation for all current tenants, including Tenant #1 and Tenant #2, to verify that required services are accurately reflected on the daily task sheets. Any care needs identified in the service plan, including toileting, bathing, dressing, hygiene, eating assistance, safety checks, housekeeping, laundry, linen changes, bed making, trash removal, skin monitoring, and other personal care services, were reviewed and corrected in the electronic task system as applicable.

For Tenant #1 and Tenant #2, the Director of Wellness/designee reviewed the current service plan, compared the plan to the task sheet, and updated the task schedule to ensure that each identified service is scheduled at the correct frequency and no required service is listed only as "PRN" when it is expected to occur routinely. Staff were re-educated that services identified in the service plan must be provided as scheduled and documented at the time of service. If a tenant refuses care, staff must document the refusal, re-approach as appropriate, and notify the nurse/designee when repeated refusals occur.

Systemic Correction / Measures to Prevent Recurrence:
The Program implemented a service plan-to-task sheet reconciliation process. Upon admission, quarterly review, annual review, and any significant change, the Director of Wellness/designee will compare the service plan to the electronic task sheet to verify that all identified tenant needs and preferences are scheduled and assigned to staff at the correct frequency.

All direct care staff, medication staff, nurses, and leadership were re-educated on the requirement to provide and document all services according to the tenant's service plan. Education included the following expectations:

1. Staff must complete scheduled services as assigned.
2. Staff must document completion of services at the time care is provided.
3. Staff must document refusals accurately and may not document a service as completed if it was refused or not provided.
4. Routine services may not be entered only as "PRN" if the service plan identifies a scheduled frequency.
5. Repeated missed services, repeated refusals, or inability to meet a tenant's needs must be reported to the Director of Wellness/designee for follow-up and possible service plan revision.

Monitoring:
The Director of Wellness/designee will audit task documentation for at least 5 tenants weekly for 4 weeks, then at least 5 tenants monthly for 3 months, to verify that services identified on service plans are reflected on task sheets and documented as completed, refused, or otherwise addressed. Audits will include personal cares, toileting, bathing, dressing, hygiene, meals/feeding assistance, housekeeping, laundry, safety checks, and other service-plan-driven tasks.

Audit findings will be reviewed by the Executive Director and Director of Wellness. Any missed documentation or missed service will be addressed through immediate staff follow-up, correction of task sheets if needed, and additional staff education or corrective action as appropriate. Trends will be reviewed through the Program's quality assurance process.

Completion Date: 07/10/2026

A151 — 481-67.5(2)e(2) Medications

Requirement: When medications are administered traditionally by the Program, the Program will maintain a list of each tenant's medications and document the medications administered.

Corrective Action for Identified Tenant:
The Director of Wellness/designee reviewed Tenant #1's current medication and treatment orders, including wound care orders, and compared available provider orders to the Medication Administration Record/Treatment Administration Record to ensure that the current medication and treatment list is accurate. Any discrepancies identified were corrected. Tenant #1's current physician/provider orders were obtained or clarified as needed and updated in the electronic record.

Staff involved in medication administration and treatments were re-educated that medication and treatment documentation must accurately reflect what occurred. Staff may not document that a medication or treatment was administered if it was not administered. If a tenant refuses medication or treatment, staff must document the refusal according to policy, re-approach as appropriate, and notify the nurse/designee for follow-up.

Systemic Correction / Measures to Prevent Recurrence:
The Program implemented an order verification and MAR/TAR reconciliation process. The Director of Wellness/designee will review new, changed, and discontinued medication/treatment orders and verify that they are accurately entered into the MAR/TAR. For outside appointments, wound clinic visits, emergency room visits, hospitalizations, and provider visits, the nurse/designee will request and review all discharge instructions and provider orders before determining whether medication or treatment orders must be added, changed, or discontinued.

All nurses and medication staff were re-educated on:

1. Accurate documentation of medication and treatment administration.
2. Documentation of refusals and missed doses/treatments.
3. The requirement to maintain a current medication and treatment list.
4. The requirement to notify the nurse/designee when orders are missing, unclear, incomplete, or inconsistent.
5. The requirement to obtain clarification from the provider before changing or omitting ordered medications or treatments.

Monitoring:
The Director of Wellness/designee will audit 5 tenant MARs/TARs weekly for 4 weeks, then monthly for 3 months, to verify that medication and treatment orders are current and that administration/refusal documentation is accurate. The audit will include review of new orders, discontinued orders, treatment orders, wound care orders if applicable, refusals, and documentation follow-up.

Audit results will be reviewed by the Executive Director and Director of Wellness. Identified discrepancies will be corrected immediately, and staff education or corrective action will be completed as appropriate. Trends will be reviewed through the Program's quality assurance process.

Completion Date: 07/10/2026

A152 — 481-67.5(2)e(3) Medications

Requirement: Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner, or PA.

Corrective Action for Identified Tenant:
The Director of Wellness/designee reviewed Tenant #1's current physician/provider medication and treatment orders, including wound care orders and hospital discharge orders, and compared those orders to the MAR/TAR. Any current discrepancies were corrected. Provider clarification was obtained as needed to ensure Tenant #1's current medications and treatments are being administered according to current orders.

The Director of Wellness/designee also reviewed current tenants who receive program-administered medications and treatments to identify whether any current medication or treatment orders required clarification, update, discontinuation, or MAR/TAR correction.

Systemic Correction / Measures to Prevent Recurrence:
The Program implemented a medication/treatment order change process for all outside appointments, wound clinic appointments, emergency room visits, hospitalizations, and provider visits. When a tenant returns from an appointment or hospitalization, the nurse/designee will:

1. Obtain discharge paperwork, provider orders, and appointment instructions.
2. Compare new orders to the current MAR/TAR and medication list.
3. Identify new, changed, continued, or discontinued medications and treatments.
4. Clarify incomplete, unclear, or conflicting orders with the provider before implementation.
5. Update the MAR/TAR and service plan/task system as applicable.
6. Communicate changes to medication staff and direct care staff.
7. Document the review and follow-up in the tenant record.

Medication staff and nurses were re-educated that medications and treatments must be administered exactly as ordered unless the provider changes or clarifies the order. Staff may not substitute an alternate treatment, continue discontinued medications, omit newly ordered medications, or change wound care frequency without provider direction.

Monitoring:
The Director of Wellness/designee will audit all new medication and treatment orders, hospital returns, ER returns, wound clinic returns, and provider appointment returns weekly for 4 weeks, then monthly for 3 months, to verify that orders were obtained, clarified as needed, entered correctly, administered as ordered, and documented accurately.

The Executive Director/designee will review audit results with the Director of Wellness. Any identified issue will be corrected immediately and addressed through staff education, process correction, and/or corrective action as appropriate. Trends will be reviewed through the Program's quality assurance process.

Completion Date: 07/10/2026

A232 — 481-69.22(3) Evaluation of Tenant

Requirement: The Program shall evaluate each tenant's functional, cognitive, and health status as needed with significant change, but not less than annually, to determine continued eligibility and changes to services needed.

Corrective Action for Identified Tenant:
The Director of Wellness/designee reviewed Tenant #1's current condition and record to verify that any current functional, cognitive, and health status needs are evaluated and reflected in the service plan. Any changes in condition or service needs identified were updated in the tenant's evaluation and service plan as applicable.

Systemic Correction / Measures to Prevent Recurrence:
The Program implemented a significant change evaluation process. A tenant evaluation will be completed following a significant change in condition, including but not limited to hospitalization, emergency room visit with change in condition, new diagnosis, significant decline, new wound, change in mobility, change in cognition, change in medication needs, or change in level of assistance required.

The Director of Wellness/designee will review hospital and ER returns to determine whether a significant change evaluation is required. If required, the evaluation will be completed by an appropriate professional and the service plan, task sheets, medication/treatment records, and staff communication tools will be updated as needed.

Nursing and leadership staff were re-educated on significant change triggers and the requirement to complete and document evaluations following a significant change.

Monitoring:
The Director of Wellness/designee will audit all hospital returns and significant change events weekly for 4 weeks, then monthly for 3 months, to verify that evaluations were completed when required and that service plans and task sheets were updated to reflect any changed needs.

Audit findings will be reviewed by the Executive Director and Director of Wellness. Any missed evaluation will be completed promptly, and staff will receive additional education or corrective action as appropriate. Trends will be reviewed through the Program's quality assurance process.

Completion Date: 07/10/2026

A268 — 481-69.25(1)i Tenant Documents

Requirement: Tenant documentation shall include medical information, health professional orders, and nurses' notes written by exception when personal or health-related care is delegated to the Program.

Corrective Action for Identified Tenant:
The Director of Wellness/designee reviewed Tenant #1's current record to verify that recent emergency room visits, hospitalizations, changes in condition, provider orders, and follow-up needs are documented in the electronic record. Any current follow-up needs were addressed and documented as applicable.

Systemic Correction / Measures to Prevent Recurrence:
The Program implemented an exception documentation process for emergency room visits, hospitalizations, significant changes, new orders, abnormal findings, refusals with clinical significance, and other health-related events. Nursing staff were re-educated that ER visits, hospital transfers, hospital returns, provider communications, changes in condition, and follow-up actions must be documented in nursing/progress notes by exception.

The nurse/designee will document:

1. Reason for ER visit, hospitalization, or provider appointment.
2. Date/time of event and return.
3. Summary of discharge instructions or provider recommendations.
4. New, changed, or discontinued orders.
5. Notifications made to provider, family/legal representative, pharmacy, and staff as appropriate.
6. Follow-up monitoring or interventions needed.
7. Any service plan, task sheet, or MAR/TAR updates completed.

Monitoring:
The Director of Wellness/designee will audit all ER visits and hospital returns weekly for 4 weeks, then monthly for 3 months, to verify that nursing notes by exception were completed and that follow-up actions were documented.

Audit findings will be reviewed by the Executive Director and Director of Wellness. Any missing documentation will be completed as appropriate based on available information, and staff will receive re-education or corrective action as needed. Trends will be reviewed through the Program's quality assurance process.

Completion Date: 07/10/2026

A285 — 481-69.26(4)a Service Plans

Requirement: The service plan shall be individualized and indicate the tenant's identified needs and preferences for assistance.

Corrective Action for Identified Tenant:
The Director of Wellness/designee reviewed Tenant #1's current service plan and updated

it as needed to include current identified needs and preferences for assistance, including any current wound-related care instructions, bathing precautions, nutritional recommendations, positioning/elevation recommendations, monitoring needs, and staff assistance required.

The Director of Wellness/designee also reviewed current provider orders and recommendations for Tenant #1 to ensure that non-medication care instructions that affect daily care are reflected in the service plan and task system as applicable.

Systemic Correction / Measures to Prevent Recurrence:
The Program implemented a process to ensure that provider recommendations and care instructions are reviewed for service plan implications. When a tenant has new orders, wound care instructions, dietary recommendations, bathing restrictions, mobility recommendations, positioning/elevation instructions, or other care-related recommendations, the nurse/designee will determine whether the service plan and task sheet must be updated.

Nursing and leadership staff were re-educated that service plans must be individualized and must identify tenant needs and preferences for assistance. Service plans will be reviewed and revised upon admission, annually, with significant change, and when new provider recommendations affect the tenant's daily care needs.

Monitoring:
The Director of Wellness/designee will audit 5 tenant service plans weekly for 4 weeks, then monthly for 3 months, to verify that identified needs and preferences are included and that provider recommendations affecting daily care are reflected in the service plan and task sheet.

Audit findings will be reviewed by the Executive Director and Director of Wellness. Any service plan omissions will be corrected promptly, and staff will receive additional education or corrective action as appropriate. Trends will be reviewed through the Program's quality assurance process.

Completion Date: 07/10/2026

A291 — 481-69.27(2)a Nurse Review

Requirement: If a tenant receives personal or health-related care, the Program shall provide for a registered nurse or licensed practical nurse via nurse delegation to monitor at least every 90 days, or after a significant change in condition, any tenant who receives program-administered prescription medications for adverse reactions, interventions/referrals, current prescription medication orders, and administration consistent with orders.

Corrective Action for Identified Tenant:
The Director of Wellness/designee reviewed Tenant #1's current medication orders, blood glucose monitoring orders, insulin orders, discontinued medications, antibiotic orders, wound care orders, and treatment orders to verify that current physician/provider orders are accurate and reflected in the MAR/TAR. Any current discrepancies were corrected, and clarification was obtained from the provider/pharmacy as needed.

The Director of Wellness/designee also reviewed Tenant #1's current condition to determine whether any additional interventions, referrals, medication monitoring, or service plan updates were needed.

Systemic Correction / Measures to Prevent Recurrence:
The Program implemented a nurse review process for tenants receiving program-administered prescription medications. Nurse reviews will occur at least every 90 days and after significant changes in condition, including hospitalization, emergency room visit with change in condition, new diagnosis, medication change, new wound/treatment order, infection, surgery, or change in monitoring needs.

The nurse review will include:

1. Review of current prescription medication orders.
2. Comparison of provider orders to the MAR/TAR.
3. Review of new, changed, and discontinued medications.
4. Review of blood glucose monitoring, insulin, treatments, and other delegated health-related tasks as applicable.
5. Review for adverse reactions, side effects, or need for intervention/referral.
6. Confirmation that medications and treatments are administered consistent with current orders.
7. Documentation of the review and any follow-up completed.

Nurses and medication staff were re-educated on nurse review requirements, significant change triggers, hospital return review, medication reconciliation, and the requirement to ensure medications are current and administered according to orders.

Monitoring:
The Director of Wellness/designee will audit nurse reviews for 5 tenants receiving program-administered medications weekly for 4 weeks, then monthly for 3 months, to verify that 90-day reviews and significant-change reviews are completed and include medication order reconciliation and follow-up.

The Executive Director/designee will review audit results with the Director of Wellness. Any missed or incomplete nurse review will be corrected promptly. Staff will receive additional education or corrective action as appropriate. Trends will be reviewed through the Program's quality assurance process.

Completion Date: 07/10/2026

Overall Quality Assurance and Ongoing Compliance

The Executive Director and Director of Wellness are responsible for implementation and oversight of this Plan of Correction. Audit results for all cited areas will be maintained and reviewed for trends. Identified trends will be addressed through additional staff education, workflow changes, service plan/task sheet corrections, medication/order reconciliation process changes, and/or personnel action as appropriate.

The Program will continue monitoring until substantial compliance is achieved and sustained. Results will be reviewed through the Program's quality assurance process to support ongoing compliance with tenant rights, service plans, medication administration, treatment administration, significant change evaluations, nurse review, and clinical documentation requirements.

Responsible Parties: Executive Director, Director of Wellness, Nurse/designee, Wellness Coordinator, Medication Staff, Direct Care Staff
Final Completion Date: 07/10/2026