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
	S0108	A. BUILDING: _____ B. WING _____	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTOM CARE	1224 13TH ST NW CEDAR RAPIDS, IA 52405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 25 Tenants with cognitive impairment: 1 Total census: 26 The following regulatory insufficiency was cited related to the essential recertification visit conducted to determine compliance with certification of an Assisted Living Program:	A 000		
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 observation, interview and record review the Program failed to update service plans as needed and develop service plans that reflected the identified needs of the tenants. This pertained to 3 of 4 tenants reviewed (Tenants #1, #2, and #4). Findings follow: 1. Record review on 12/17/25 of Tenant #1's file	A 350		

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

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A 350	Continued From page 1	A 350		

revealed the Assisted Living Service Plan reflected Tenant #1's diagnoses included dementia. Tenant #1 scored a 22/30 on the Mini Mental State Examination. The service plan indicated Tenant #1 could no longer use the pendant. He did not know what it was or how to use it.

Continued record review revealed Tenant #1's service plan did not reflect how staff monitored Tenant #1 in the absence of a personal emergency response (PER) pendant.

When interviewed on 12/17/25 at 4:07 p.m. the Registered Nurse (RN) and Social Worker (SW) indicated in place of a PER pendant, increased checks were completed. They confirmed checks were not reflected on Tenant #1's service plan.

2. Record review on 12/17/25 of Tenant #2's file revealed the Assisted Living Service Plan indicated Tenant #2 had a suprapubic catheter. Staff on the second shift changed the bag over (day bag to night bag). A nurse completed catheter changes once monthly. On 12/02/25 the service plan was updated and directed staff to empty the catheter bag and check the bag every few hours. The service plan was also updated on 12/05/25 and reflected Macrobid (antibiotic) was ordered twice daily for 5 days.

When interviewed on 12/17/25 at 10:25 a.m. Staff B reported staff spent a lot of time with Tenant #2. She indicated it was mainly the catheter care and he was never satisfied with the catheter. Staff emptied the bag and changed the bag over. Tenant #2's family also wanted to video call to see if staff was doing things correctly.

Continued record review revealed Tenant #2's

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A 350	Continued From page 2 service plan did not reflect which shift changed the catheter bag back to a day bag. It also did not reflect the reason for the antibiotic prescribed. When interviewed on 12/17/25 at 4:07 p.m. the RN and SW indicated the antibiotic was prescribed for a urinary tract infection. First shift staff changed the night bag (catheter) back to a day bag and it was not reflected on the service plan. 3. Record review on 12/17/25 of Tenant #4's file revealed the Assisted Living Service Plan reflected staff administered all of his medications. The plan also indicated he was diabetic and a nurse administered his insulin. When observed on 12/17/25 during the medication pass that started at approximately 11:23 a.m. Staff A administered medications to seven tenants including Tenant #4. She also prepared medications to go for one tenant leaving for an appointment. When observed in his apartment, Tenant #4 had a continuous glucometer and his blood glucose reading was 215 at the time of the medication pass. Staff A administered his insulin based on the blood glucose reading (scheduled and sliding scale insulin). Continued record review revealed Tenant #4's service plan did not reflect the continuous glucometer and who managed it, including sensor changes. When interviewed on 12/17/25 at 4:07 p.m. the RN and SW confirmed the continuous glucometer was not on the service plan.	A 350		