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
	S0198	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS MEMORY SUPPORT AL	420 KENYON ROAD FORT DODGE, IA 50501

(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: 8 Tenants with cognitive impairment: 13 Total census: 21 The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program.	A 000	See attached POC 11/24/25	
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 when needed and failed to have service plans reflect service needs of the tenants. This pertained to 1 of 4 tenants reviewed (Tenant #1). Finding follows:	A 350		

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A 350	Continued From page 1 Record review on 9/18/25 revealed Tenant #1's Incident Report, dated 8/16/25 indicated at 5:20 a.m., Tenant #1 came out of her apartment, as staff approached her, she opened another tenant's apartment door and was in the apartment. Staff redirected Tenant #1 out of the other apartment and back to her apartment. The report noted Tenant #1 came back out of her apartment and walked around the hallway. She got close to another tenant's door, staff attempted to approach Tenant #1 before she opened the door. Tenant #1 opened the door of the other tenant's apartment. Staff attempted to redirect the tenant but she became aggressive, raised her voice and hit the staff's wrist off of the apartment door. The tenant in the apartment observed the aggression, became scared and asked Tenant #1 to leave the apartment. Tenant #1 became very upset. Staff called the lead staff to assist. The lead staff redirected her back to her apartment. Tenant #1 yelled at the lead staff and eventually went to bed. Continued review revealed the Adult Services Monitoring Entrance Form, completed by the Program listed wandering behavior for Tenant #1. When interviewed on 9/18/25 at 12:40 p.m., Staff A indicated staff kept an eye on Tenant #1. She needed more assistance from staff. Staff expressed to the nurses she needed to be in another area of the building. Further record review revealed Tenant #1's service plan, dated 9/05/25, failed to reflect a wandering behavior for Tenant #1 as indicated in her incident report and on Adult Services Monitoring Entrance Form. When interviewed on 9/18/25 at 3:41 p.m. the	A 350		

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A 350	Continued From page 2 Independent and Assisted Living Director confirmed wandering was not indicated on the service plan for Tenant #1.	A 350		

Friendship HAVEN

December 8, 2025

Please see the Plan of Correction outlined below as evidence of correction and plans for continued regulatory compliance for Gardens Memory Support ALP.

Corrective Action Plan

1. **Issue Identified**
    - On **August 26, 2025**, the nursing assessment noted the resident had a pattern of wandering.
    - This information did not transfer to the Service Plan as expected.
2. **Corrective Action Taken**
    - On **November 24, 2025**, a request was sent to the EHR vendor to address the missing subcategory.
    - The EHR was updated so that data from nursing assessments now transfers automatically to Service Plans.
3. **Outcome**
    - The resident's Service Plan now includes the pattern of wandering.
    - Future nursing assessments will automatically populate this information in Service Plans.
4. **Follow-Up**
    - No ongoing follow-up required due to successful EHR update.