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FORM APPROVED

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
	S0211	A. BUILDING: _____ B. WING _____	C 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR VALE	100 POPPE LANE NASHUA, IA 50658

(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: 16 Tenants with cognitive impairment: 0 Total census: 16 The following regulatory insufficiency was cited during the investigation of Complaint # 131077-C.	A 000	see attached POC 5/13/26	
A 116	481-67.2(2) Program Policies and Procedures 67.2(2) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to follow policies related to accident and emergency responses and incident reports for 2 out of 3 tenants reviewed (Tenant C1, Tenant C2). Findings follow: 1. Record review on 4/29/26, revealed Tenant C1 had an incident report dated 12/21/25. The incident report revealed Staff A discovered Tenant C1 in his room between 2:00 p.m. to 2:30 p.m. incontinent and sitting on his floor. Tenant C1 reported he felt cold and weak. Staff A took Tenant C1's vitals and called the Nurse Manager for directives. The Nurse Manager instructed Staff A to call the non-emergency number to request assistance getting Tenant C1 up off of the floor safely. After the paramedics arrived, it was determined Tenant C1 required evaluation at the hospital and was taken by ambulance.	A 116	A116 Cedar Vale does follow policies and procedures established by the program. 1. The Nurse Manager, Director and/or director assignee will ensure all staff review and sign off on the policy and procedure manual upon hire, when policy is updated and/or new, and annually. 2. The Nurse Manager, Director, and/or Director assignee will review the accident and emergency responses and incident policy with all staff at the next staff in-service. They will also keep a signed checklist of the policy and procedure manual upon hire and annually in their staff files. 3. Director or Director assignee will monitor that the policy and procedure manual will be signed upon hire, when changes occur, and annually. 4. This was completed on 5/13/2026.	

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A 116	Continued From page 1 Nurse's notes dated 12/22/25, revealed the Nurse Manager was called at 2:30 p.m. by Staff A and reported Tenant C1 had apparently fallen on his way to the restroom and required assistance. The Nurse Manager instructed Staff A to call non-emergency to request assistance with a lift. Staff A called the Nurse Manager back to report they took Tenant C1 to the hospital to be evaluated. A nurse's note dated 12/30/25 revealed Tenant C1 was not going to return to the Program as he was on hospice and transferring to long-term care services. On 4/29/26, a report obtained from the hospital Tenant C1 was admitted with a urinary tract infection, fever, sepsis, bacteremia, known Alzheimer's disease, acute kidney injury, and rhabdomyolysis. Tenant C1 was guarded and unresponsive in the hospital setting. An emergency medical technician report revealed the non-emergency number was called at 2:36 p.m. When interviewed on 4/29/26 at 9:19 a.m., Staff A reported she worked 4:00 a.m. to 4:00 p.m. on 12/21/25. Staff A woke up Tenant C1 at 5:55 a.m. and he was not his normal self. Staff A reported he was usually smiling and ready to get up but on this day he was sleeping in his recliner, dressed and was not very talkative. Staff A added Tenant C1 refused to come out for coffee and refused breakfast which he typically enjoyed. Staff A confirmed she checked on him every two hours and he mostly slept. Staff A indicated she observed him in his chair asleep at 10:00 a.m. and he refused to come out for lunch at 12:00 p.m. and continued to nap in his chair. Staff A indicated around 2:00 p.m. she checked on him and discovered him sitting on the floor with his	A 116		

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A 116	Continued From page 2	A 116		

pants off. Tenant C1 reported to Staff A he was cold and had not felt good. Staff A observed Tenant C1 urinate on the floor while she talked to him and noted he was incontinent of bowel as he had it on his hands and other areas of his body. Staff A added Tenant C1 had his pendant but had not used it that day.
Staff A indicated she took Tenant C1's vitals and called to report the incident to the Nurse Manager at around 2:30 p.m. The Nurse Manager instructed Staff A to call the non-emergency number for assistance if she could not get him off the floor. Staff A called non-emergency. Staff A reported when non-emergency arrived they asked her some questions and then determined they were going to transport Tenant C1 to the hospital for evaluation. Staff A indicated she called the Nurse Manager to report the transport.
Staff A reported Tenant C1 walked on his own with no devices. Staff A added she believed Tenant C1 had never fallen before or been incontinent. Staff A was not aware of any previous concerns with Tenant C1 or illness prior to her shift. Staff A indicated Tenant C1 refused to catheterize himself that morning when prompted which was not out of the ordinary.
Staff A confirmed she had not called the Nurse Manager to report Tenant C1's refusal to eat breakfast and lunch and his increased sleeping prior to his incident at 2:00 p.m.

When interviewed on 4/29/26 at 9:55 a.m., Staff B reported she worked 4:00 p.m. on 12/20/25 to 4:00 a.m. on 12/21/25. Staff B indicated Tenant C1 refused to eat supper on the night of 12/20/25 and reported he felt tired and went to bed early between 5:30 p.m. to 6:00 p.m. Staff B indicated he wore a shirt and underwear to bed. Staff B completed checks on him that night and asked him if he wanted something to eat but he refused.

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A 116	Continued From page 3 Staff B indicated on a typical night, Tenant C1 would get up to use the restroom and occasionally come out and see what Staff B was doing. Staff B reported Tenant C1 had no previous falls she was aware of and no incidents of incontinence she was aware of. Staff B was not sure if she passed on to the next shift that Tenant C1 skipped supper as that was not completely out of the ordinary. Staff B believed Tenant C1 was just tired that night. Staff B reported Tenant C1 had refused to catheterize himself that specific night but that was not unusual for him to refuse. Staff B had not reported to the Nurse Manager Tenant C1 refused supper and went to bed early. When interviewed on 4/29/26 at 10:07 a.m., the Nurse Manager indicated she had completed a set of evaluations due to a change of condition for Tenant C1 on 12/19/25, just a few days prior to his incident. The Nurse Manager reported he had no changes in his health but displayed changes in his cognition with increased wandering. She moved his GDS score to a four. The Nurse Manager reported Tenant C1 self catheterized himself twice daily with staff prompts. Tenant C1 used no assistive devices when he walked and had no issues with falls or incontinence. The Nurse Manager believed Staff A found Tenant C1 just after 2:00 p.m., and called her at around 2:30 p.m., after she assessed him and completed vitals. The Nurse Manager added the paramedics took him to be evaluated as his oxygen levels were low when they arrived. The Nurse Manager added Tenant C1 was likely embarrassed as he preferred to stay independent and prided himself in being clean. On 4/29/26, a review of the Program policy, Accident and Emergency Response Policy, dated	A 116		

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A 116	Continued From page 4 1/11/24, included the following guidance for staff: Staff would notify the registered nurse (RN) if a resident became ill or displayed changes in behavior. When interviewed on 4/29/26 at 11:30 a.m., the Nurse Manager confirmed she received no calls earlier than 2:30 p.m. regarding the fact Tenant C1 refused 3 meals, coffee, and slept most of the night and morning. 2. Record review on 4/29/26 revealed Tenant C2 had a diagnosis of schizoaffective disorder, bipolar disorder, borderline intellectual functioning, generalized anxiety disorder and chronic kidney disease. Tenant C2 had no incident reports on file. Tenant C2's nurse's notes revealed the following incidents reported in November and December of 2025: a. 11/25/25 - Tenant C2 argued with a staff member and became angry. Tenant C2 got up into the staff member's face. Tenant C2 redirected to his apartment. b. 11/28/25 - Tenant C2 used call light repeatedly to discuss unusual topics. At noon, staff took a lunch tray into Tenant C2's room and he requested to play chess. Staff told Tenant C2 they could not at that moment due to it being lunch time but maybe in the afternoon and Tenant C2 stated "F*** you! I should kill you!" Continued to say unusual things. c. 12/3/25 - Tenant C2 was up all night. Staff found Tenant C2 sitting in his feces and ate instant coffee by the spoonful. Tenant C2 was acting out of character. Staff called 911 and	A 116		

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A 116	Continued From page 5 Tenant C2 was sent to the hospital. d. 12/9/25 - Tenant C2 ate handfuls of sugar. Tenant C2 packed up his entire room into garbage bags and created a makeshift bed in his shower. Staff called 911. Tenant C2 was sent to the hospital. e. 12/12/25 - Tenant C2 found in his room sitting naked in a wheelchair. Tenant C2 was giving himself a sponge bath with newspapers. Tenant C2 had napkins and silverware in his microwave thinking he was making dinner. Tenant C2 flooded his apartment with the kitchen sink. Tenant C2 was sent to the hospital. On 4/29/26, a review of the Program policy titled: Incident Report, date 2/1/22, included the following guidance for staff: an incident report shall be completed for vulgar/explicit outburst, verbalized threats, or an anxiety/depression event. When interviewed on 4/29/26 at 11:30 a.m., the Nurse Manager confirmed Tenant C2's incidents identified in his nurse's notes should have been reported on incident report forms. When interviewed on 4/29/26 at 12:00 p.m., the Regional Director of Operations, the Director, and the Nurse Manager confirmed the above policies were not followed.	A 116		