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
	S0213	A. BUILDING: _____ B. WING _____	08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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: 33 Tenants with cognitive impairment: 13 Total census: 46 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with licensing rules for an Assisted Living Program for People with Dementia (ALP/D).	A 000		
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 observation, interview and record review the Program failed to ensure 2 of 4 tenants reviewed received adequate care and services (Tenant #1 and Tenant #4) as well as potentially affecting all tenants residing on the dementia specific unit. Findings follow: 1) An observation of lunch on the dementia specific unit on 8/10/26 began at 11:45 AM. A total of eight tenants were served glazed meat loaf, mashed potatoes and carrots on dishes with rounded edges. Milk was the primary drink offering. Staff A and Staff F assisted in serving	A 122		

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A 122	Continued From page 1 the food, supervising and bringing tenants to/from the dining room. Observations included: a. Tenant #1 sat in a wheelchair 8-9 inches from the table. He had to stretch to reach his plate throughout the meal. b. At 11:50 AM Tenant #9 poured her milk over her food. No staff were in the dining room. She continued to eat her food. Staff A removed Tenant #9's plate at 11:58 AM and provided her with a new dish at 12:00 PM. She moved Tenant #9's cup from her reach. When Staff F returned to the room she moved Tenant #9's drink back within her reach. c. At 12:01 PM Tenant #10 dragged her cup through her plate of food, Tenant #11 took the cup off the plate. d. At 12:05 PM Tenant #10 put carrots in her dessert. e. At 12:09 Tenant #10 began eating meatloaf and mashed potatoes with her fingers. f. At 12:17 Tenant #9 began to pour her drink on the table. Staff A gave verbal and physical prompts for Tenant #9 to stop, which she did. g. At 12:20 Tenant #4 stood up from table and began talking with Tenant #1. Tenant #11 vocalized and pointed towards Tenant #4, attempting to get Staff F's attention. Staff F was washing dishes with her back to the room. When Tenant #11 got Staff F's attention, she said, "I know" and finished a conversation with Tenant #3. 15-20 seconds later she walked to Tenant #4, put her arm around the tenant and led her to the couch where she sat down.	A 122		

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A 122	Continued From page 2 A review of Tenant #4's Resident Assessment dated 6/13/26 noted she needed an assist of one for transfers. She required redirection at mealtime to be reseated. Tenant #4 was a high fall risk. Staff should remind her to wait for staff assistance. Assistance should be offered in and out of chairs and furniture. She also required an escort when walking. When interviewed on 8/10/26 at 12:30 PM Staff A reported the noon meal experience this day was typical, although there was generally only one staff present. Staff F helped with lunch when she was able, but she had other responsibilities within the building. Staff B reported there was usually only one staff doing the lunch duty in the dementia specific unit on 8/10/26 at 12:25 PM. It was difficult to monitor all tenants at lunch with only one staff person. 2) a. Record review of a Resident Information sheet for Tenant #1 showed an admission date of 7/3/26. During an interview with the Executive Director on 8/11/26 at 1:24 PM she explained he did not physically move in until 7/6/26. The July 2026 Medication Administration Record (MAR) for Tenant #1 identified staff began administering medication to him at 8:00 AM on 7/9/26. During an interview with Tenant #1's wife on 8/11/26 at 1:30 PM she explained when her husband moved to the Program she dropped off medication boxes filled with his home medicine. It was her belief the Program gave him medication from the time he admitted. Record review revealed a Medication Services	A 122		

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policy, dated 6/13/24, which noted the Executive Director would ensure medication-related services requested by each tenant would be provided. All medication handled by staff members would be documented on the MAR in accordance with state regulations and the community's policy and procedures manual.

During an exit meeting with the Executive Director on 8/11/26 at 2:15 PM she stated she was not present when Tenant #1 moved to the building but staff should have documented the administration of his medication and/or ensured he received medication the first three days of his stay.

b. A review of Incident Reports for Tenant #1 revealed the following:
- On 7/7/26, staff report during rounds, Tenant #1 was found sitting on the floor. The Executive Director added an addendum to the incident report on 7/7/26 of staff to increase frequency of safety checks as tenant is new to the facility.

- On 7/21/26 at 2:20 AM, Tenant #1 was found on the floor lying on his back/buttocks next to his bed during routine hourly checks. An intervention was added on 7/21/26. The Executive Director requested a body pillow to use in his bed to help with positioning.

- During rounds on 7/28/26 at 10:55 PM Tenant #1 was found on the floor sitting next to his bed. Staff were to ensure he was properly positioned in bed to promote his safety and comfort.

A review of Tenant #1's Task Administration Record for the months of July 2026 and August 2026 revealed no tracking for safety checks or an increase in safety checks following his fall on

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A 122	Continued From page 4 7/7/26. There was no direction for staff on the task sheets to ensure he had his body pillow in his bed or was properly positioned to promote comfort and prevent falls. 3) Record review of incident reports for Tenant #4 revealed the following: - On 6/1/26 at 5:20 PM, Tenant #4 reached for another tenant's walker, lost her balance and fell. She landed on her back and hit her head. No injury was noted. An intervention was added for staff to remind Tenant #4 she does not use an assistive device. - Staff heard Tenant #4 crying on 6/7/26 at 2:00 PM and found her on the floor holding her face. Her nose was bleeding and the right side of her forehead was scraped. Another tenant's family reported Tenant #4 tripped over the couch and fell to her knees without catching herself. An intervention was added to provide increased supervision and safety cueing during mobility activities as needed to reduce her fall risk. - On 6/19/26 at 7:40 PM Tenant #4 experienced an unwitnessed fall in her bedroom. Staff discovered her on the floor next to her bed with her blanket. She was assessed for injury and denied pain. An intervention was added on 6/19/26 for staff to ensure her blankets were properly tucked to reduce entanglement risks. A review of Task Administration Records for Tenant #4 for the months of July, 2026 and August, 2026 revealed no entries about supervision and safety cueing or how this might have been increased to reduce her fall risk. There was no information on the task administration record directing staff to ensure her	A 122		

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A 122	Continued From page 5 blankets were properly tucked. The Program failed to ensure Tenant #1 and Tenant #4 received appropriate services to address their falls. During an interview with the Executive Director on 8/11/26 at 11:55 AM she confirmed there was no way to ensure the interventions listed on the incident reports were completed by staff if they weren't documented on the task administration records.	A 122		
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to administer medication as prescribed to 2 of 8 current tenants reviewed (Tenant #1 and Tenant #5). 1) Record review on 8/10/26, of a Resident Information sheet for Tenant #1, indicated an admission date of 7/3/26. Staff began providing	A 152		

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A 152	Continued From page 6 Tenant #1 with medication on 7/9/26 per documentation from the Medication Administration Record for the month of July 2026. When interviewed on 8/11/26 at 1:30 PM Tenant #1's wife reported when her husband moved in, she brought cassettes with his medication from home the staff could give to him until the Program obtained medication from their pharmacy. She did not know exactly what happened but she understood Program staff administered medication to her husband as soon as he moved in. The Program had a Client Medication Report for Tenant #1 dated 7/6/26 with a list of medication from his Hospice physician. The Executive Director reported in an email on 8/11/26 at 1:24 PM Tenant #1's official move in date was 7/6/26. When interviewed on 8/11/26 at 11:55 AM she explained she was on vacation when Tenant #1 moved in and could not state why he did not receive his medication for three days. 2) Observation of a medication pass on 8/10/26 at 11:10 AM revealed Staff A administered Diclofenac gel to Tenant #5. She doffed a pair of gloves and squeezed an unknown amount of Diclofenac Gel 1% onto the pads of her fingers and applied it to both of Tenant #5's knees. The Program had a list of Active Medications for Tenant #5 which was signed by her primary care provider on 1/23/26. It included Diclofenac Gel 1%, apply topically to legs, 2 grams three times daily for chronic leg pain.	A 152		

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A 152	Continued From page 7 When interviewed on 8/11/26 at 11:55 AM the Executive Director confirmed Staff A failed to measure the quantity of medication applied to Tenant #5's legs prior to application. 3. Record review revealed a Medication Services policy (dated 6/13/24) which noted the Executive Director would ensure the medication related services required for each tenant would be provided. All medications staff members handled, stored and assisted with would be documented on the Medication Administration Record.	A 152		
A 281	481-69.26(2) Service Plans 481-69.26(231C) Service plans. 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans were developed and signed for 2 of 2 tenants reviewed who moved in within the past three months (Tenant #1 and Tenant #3). Findings follow:	A 281		

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A 281	Continued From page 8 1. Record review on 8/10/26 revealed Tenant #1 had an occupancy agreement signed by his legal representative on 6/30/26. There was no service plan in his file dated 6/30/26 or earlier. 2. Tenant #4 had an occupancy agreement which was signed by her legal representative on 6/8/26. The Executive Director signed the service plan on 6/8/26 but the tenant did not sign the plan. 3. The Executive Director confirmed the Program failed to ensure service plans were developed and signed before the tenant signed the occupancy agreement during an exit meeting on 8/11/26 at 2:15 PM.	A 281		
A 282	481-69.26(3) Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. The service plan shall be signed by all parties, including the tenant or tenant's legal representative. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to update service plans with a change of condition for 3 of 4 tenants reviewed (Tenant #1, Tenant #3 and Tenant #4). Findings follow: 1) a. Record review on 8/10/26 of a Resident	A 282		

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A 282	Continued From page 9 Information Sheet for Tenant #1 revealed an admission date of 7/3/26. A service plan dated 7/30/26 for Tenant #1 revealed he required the assistance of one staff with pivot transfers using a gaitbelt, walker and wheelchair. They were to remind him to wait for assistance to transfer. Staff should provide transfer assistance with good technique to protect Tenant #1 and care staff. Additional observation on 8/10/26 at 10:35 AM revealed Staff A assisted Tenant #1 to the toilet. She took his wheelchair into the bathroom and attempted to lift him from the chair with a gait belt, but was unable to get him up. Staff A brought Staff B into the bathroom and with two staff they transferred him from the wheelchair onto the toilet and then back to his wheelchair when he was finished. Observation on 8/11/26 at 1:30 PM revealed Staff C transferred Tenant #1 to change his incontinence undergarment. Prior to entering Tenant #1's apartment Staff C stated she hoped Tenant #1 would be more helpful than he was in the morning as she required the assistance of a second staff to get him dressed and change his incontinence brief. During the observation, she was able to change Tenant #1's incontinence brief on her own while he sat in his wheelchair. The process involved him rising and sitting six times as his brief was removed and a new one replaced. Tenant #1's wife was in his apartment when this occurred and stated there were usually two staff in his apartment during the transferring process. When interviewed on 8/10/26 at 10:17 AM Staff D explained Tenant #1's care plan noted he required the assistance of one staff with a gait belt, but about 70% of the time he needed help	A 282		

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from two staff with a gait belt. There were even times a third staff was required for transfers as he reported pain. She worried about his safety and the safety of staff during the transferring process.

When interviewed on 8/11/26 at 10:35 AM Staff C stated while Tenant #1 could be transferred alone it was difficult if he was not willing to help, and there were quite a few days he was not willing to help. He often believed the staff were trying to hurt him during the transferring process and they would stop if he said, "ow".

When interviewed on 8/10/26 at 9:55 AM Staff B reported Tenant #1 was a two-person lift over 50% of the time. He required the help of two staff when standing and dressing.

The Executive Director was interviewed on 8/11/26 at 12:53 PM. She was aware there were times Tenant #1 was a two person assist but believed with the right training he could be transferred with only one person. The Executive Director confirmed Tenant #1's service plan was not updated when he had a change of condition requiring additional assistance with transferring.

b. A review of incident reports for Tenant #1 revealed the following:
- Staff reported Tenant #1 was found on the floor on 7/7/26 at 4:00 AM following an unwitnessed fall. No injuries were noted.

- On 7/21/26 at 2:20 AM Tenant #1 was found on the floor lying on his back/buttocks next to the bed during routine hourly checks. He had no visible injuries.

- On 7/28/26 at 10:55 PM Tenant #1 was found

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during rounds on the floor sitting next to his bed. He did not sustain injuries.

Record review revealed a Falls policy, dated 6/13/24, which noted all tenants were evaluated for fall risk and their service plan would be updated accordingly. Should a tenant experience a fall, staff would provide immediate care and follow through with service planning. Each tenant's service plan would be reviewed and updated whenever a tenant had a: first fall, two or more falls within 30 days or a change of condition.

Tenant #1 moved to the Program on 7/3/26. The Program did not develop an initial service plan. The Program's Falls policy indicated a service plan should have been updated following the 7/7/26 fall (first fall). A service plan was written on 7/30/26.

2) Record review revealed Tenant #3's service plans dated 6/8/26 and 7/8/26 noted she did not exhibit present or past behaviors. Resident Assessments dated 6/8/26 and 7/8/26 noted she did have past or present depression and an altered sleep schedule. Tenant #3 did not exhibit sexually inappropriate behavior.

Continued record review revealed observation notes for Tenant #3 identified she moved to the Program on 6/8/26. She had a diagnosis of unspecified dementia. On 6/13/26 staff reported she attempted to get a male tenant into her room. Around 5:00 PM that day, she came out of her room in a shirt and underwear and asked the same male to go into her room and help her. Staff redirected Tenant #3 to her room and reminded her no male tenants should be in her

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room. On 7/7/26, Tenant #3 kept coming out of her room without clothing on.

When interviewed on 8/10/26 at 4:10 PM Staff E reported Tenant #3 rarely came out of her apartment any longer. She had sexual issues when she first moved to the Program but did not any longer. Tenant #3 would take all of her clothing off when entering her apartment but did not leave her apartment undressed.

When interviewed on 8/11/26 at 10:35 PM Staff C explained Tenant #3 might have her clothing on backwards but did not leave her apartment undressed any longer. She did fully undress regularly when in her apartment.

When interviewed on 8/11/26 at 11:55 AM the Executive Director reported she did not understand the need to update a service plan for a situation only happening one time. The Executive Director was unaware Tenant #3 would fully undress in her apartment. She confirmed the Program failed to update Tenant #3's service plan to add interventions to assist staff with their response when she left her apartment undressed, if she would engage with other tenants in a sexual manner or to ensure she was given privacy when in her apartment unclothed.

3) Record review revealed Tenant #4's service plan dated 6/13/26 noted she required the assistance of one staff for transfers. Staff were to escort her or if using her wheelchair they should push it due to her physical limitations.

A review of Incident Reports revealed the following:
- On 6/14/26 at 6:36 PM staff walked into the dining room and found Tenant #4 on the floor

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bleeding from her right eyebrow. After the nurse on call was contacted she watched the cameras and found when Tenant #4 stood up her foot got caught on the table and she fell to the floor. Tenant #4's husband was contacted as well as the on-call hospice nurse. When the hospice nurse responded, she applied steri-strips to Tenant #4's right eyebrow.

- Staff accompanied Tenant #4 to her room to get ready for bed on 6/16/26 at 8:15 PM. When staff was getting her pajamas, she slid out of her wheelchair and hit her left rib area on the foot rest and began crying and holding her left side. The hospice nurse was contacted and evaluated Tenant #4.

- On 6/19/26 at 7:40 PM Tenant #4 experienced an unwitnessed fall in her bedroom. Staff discovered her on the floor next to her bed with her blanket. She was assessed for injury and denied pain.

- Staff saw Tenant #4 trip over the leg of a chair, landing on her bottom/side on 7/5/26 at 1:11 PM. She favored her left leg when she got up and said her hip and side hurt.

Record review revealed a Falls policy, dated 6/13/24, which noted all tenants were evaluated for fall risk and their service plan would be updated accordingly. Should a tenant experience a fall, staff would provide immediate care and follow through with service planning. Each tenant's service plan would be reviewed and updated whenever a tenant had a: first fall, two or more falls within 30 days or a change of condition.

The Program failed to follow the Falls policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0213	A. BUILDING: _____ B. WING _____	08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE HILLS AT TIPTON	219 SOUTH CEDAR STREET TIPTON, IA 52772

(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 282	Continued From page 14 (6/13/24) by updating Tenant #4's service plan after she experienced two or more falls within 30 days. She had a service plan dated 6/13/26 and experienced falls on 6/14/26, 6/16/26, 6/19/26 and 7/5/26. During an exit meeting on 8/11/26 at 2:15 PM the Executive Director confirmed she failed to update Tenant #4's service plans after she experienced more than two falls.	A 282		