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
	S0265	A. BUILDING: _____ B. WING _____	C 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPPER CREEK SENIOR LIVING	609 HWY 150 N WEST UNION, IA 52175

(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: 2 Tenants with cognitive impairment: 7 Total census: 9 The following regulatory insufficiencies were cited during the investigation of Complaint #130147-C.	A 000	see attached POC 10/22/25	
A 125	481-67.2(1)d Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: d. The incident report shall include statements from individuals, if any, who witnessed the incident. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the Program failed to ensure incident reports included witness statements. This pertained to 4 out of 4 tenants reviewed (Tenant C1, Tenant C2, Tenant #1, and Tenant #2). Findings follow: Record review on 10/21/25 revealed the Program's incident reports without witness statements attached to the reports for review. Tenant C1's record revealed two unwitnessed falls. Tenant C2's record revealed four	A 125	A125 Copper Creek Senior Living does follow policies and procedures as listed in the policy handbook. 1. The Regional Nurse, Director and/or director assignee will keep all incident reports and witness statements on file. 2. The Regional Nurse, Director, and/or Director asignee will keep all incident reports and witness statements in a designated area for 5 years. 3. Director or Director assignee will monitor that all incident reports are put in the file after all of the documentation is finished. 4. The Incident Report file was created on 10/22/2025.	

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A 125	Continued From page 1 unwitnessed falls. Tenant #1's record revealed seven unwitnessed falls. Tenant #2's record revealed four unwitnessed falls. When interviewed on 10/21/25 at 10:50 a.m., the Registered Nurse (RN), indicated staff completed incident reports with witness statements. According to the RN, she took the staffs' completed incident reports and created a final incident report herself. The RN reported she then destroyed the original staff documentation. The RN confirmed the incident reports the RN completed failed to contain all of the staff names who were witness to the events of each event documented. On 10/22/25 at 2:00 p.m., the Executive Director, the RN, and the Resident Care Coordinator confirmed the above findings. The RN confirmed she failed to keep witness statements after she completed the final copies of incident reports.	A 125		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the Program failed to ensure tenants received	A 160		

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A 160	Continued From page 2 adequate and appropriate care. This pertained to 4 out of 4 tenants reviewed (Tenant #1, Tenant #2, Tenant C1, Tenant C2). Findings follow: 1. Record review on 10/21/25 of Tenant C1's record revealed the following diagnoses: central nervous system lymphoma, history of falls, cerebellar stroke syndrome, frontal lobe and executive function deficit, and an admission to hospice on 5/19/25 due to a brain neoplasm. The Program admitted Tenant C1 on 4/08/25. Tenant C1's occupancy agreement dated 4/08/25, documented Tenant C1 was to receive hourly safety checks daily. Tenant C1's service plan, dated 5/19/25 indicated Tenant C1 was an elopement risk. The service plan directed staff to provide supervision and redirection to avoid and prevent wandering episodes and two hour safety checks. Tenant C1's most recent service plan dated 7/11/25, directed Tenant C1 needed to be checked, changed if incontinent, turned and repositioned if needed every two hours. A review of Tenant C1's incident reports revealed on 5/24/25 and 7/06/25 Tenant C1 fell without a witness. Tenant C1 was on hospice at the time of his 7/06/25 fall and comfort measures were provided with pain medication. Tenant C1's occupancy agreement failed to match the staff directives given in the 5/19/25 or 7/11/25 service plans. 2. Record review on 10/21/25 of Tenant C2's record revealed the following diagnoses: insomnia, hyperlipidemia, hospice admission, anxiety disorder, Alzheimer's disease, muscle weakness, down syndrome, abnormalities of gait, repeated falls, and cognitive communication deficit. The Program admitted Tenant C2 on 8/24/23. Tenant C2's occupancy agreement dated 8/24/23, documented Tenant C2 was to receive	A 160	A160 Copper Creek Senior Living does follow tenant rights to receive care, treatment and services which are adequate and appropriate. 1. The Regional Nurse, Director and/or Director assignee will make sure all tenants are assigned hourly checks per their occupancy agreements. 2. The Regional Nurse, Director and/or Director assignee will make sure all hourly checks are assigned upon admission and with all reviews and/or significant changes. 3. Director or Director assignee will check all service plans when completed. 4. The hourly checks were all assigned and implemented on 10/22/2025.	

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A 160	Continued From page 3 hourly safety checks daily. Tenant C2's most recent service plan, dated 9/05/25 directed he received nightly safety checks every two hours. A review of Tenant C2's incident reports revealed on 7/26/25, 8/17/25, 8/22/25, and 9/08/25 Tenant C2 fell without a witness. Tenant C2 bled from his head after his fall on 7/26/25. Hospice assessed and treated the injury. Tenant C2's occupancy agreement failed to match the staff directives given in the 9/05/25 service plan. 3. Record review on 10/21/25 of Tenant #1's record revealed the following diagnoses: atrial fibrillation, history of falls, and cellulitis. The Program admitted Tenant #1 on 3/14/25. Tenant #1's occupancy agreement dated 3/14/25, documented Tenant #1 was to receive hourly safety checks daily. Tenant #1's most recent service plan dated 8/29/25 directed she was to receive nightly safety checks every two hours. A review of Tenant #1's incident reports revealed Tenant #1 on 6/20/25, 7/14/25, 8/13/25, 9/22/25, 10/09/25, and 10/15/25 fell without a witness. Tenant #1's falls resulted in no injuries. Tenant #1's occupancy agreement failed to match the staff directives given in the 8/29/25 service plan. 4. Record review on 10/22/25 of Tenant #2's record revealed the following diagnoses: skin carcinoma, hyperlipidemia, Alzheimer's disease, chronic kidney disease, and hypertension. The Program admitted Tenant #2 on 7/26/23. Tenant #2's occupancy agreement dated 7/26/23, documented Tenant #2 was to receive hourly safety checks daily. Tenant #2's most recent service plan dated 9/05/25 revealed he was to receive nightly safety checks every two hours. A review of Tenant #2's incident reports revealed on	A 160		

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A 160	Continued From page 4 7/21/25, 8/12/25, 8/15/25, and 9/01/25 fell without a witness. Tenant #2 received a scratch on his hand from his fall on 9/01/25. Tenant #2's occupancy agreement failed to match the staff directives given in the 9/05/25 service plan. When interviewed on 10/21/25 at 10:57 a.m., Staff A indicated she checked on all tenants every two hours. Staff A confirmed Tenant C1, Tenant C2, Tenant #1, and Tenant #2 all received two hour safety checks. When interviewed on 10/21/25 at 12:57 p.m., Staff B reported she checked all tenants every hour. When interviewed on 10/21/25 at 12:26 p.m., Staff C explained she worked in the memory care once and she completed safety checks on tenants every two hours. When interviewed on 10/21/25 at 12:49 p.m., Staff D indicated she checked on tenants who stayed in their rooms every two hours. Staff D explained many of the tenants in the memory care tended to stay in the common areas with staff and were observed more than every two hours. When interviewed on 10/21/25 at 1:16 p.m., Staff E reported she completed safety checks on all tenants every two hours. When interviewed on 10/22/25 at 10:04 a.m., Staff F explained when she first started working at the Program, safety checks on tenants were every hour. Staff F confirmed safety checks on tenants were now completed every two hours. Staff F pointed out only the night time checks	A 160		

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A 160	Continued From page 5 were documented and staff did not document safety checks during the day time When interviewed on 10/22/25 at 1:02 p.m., the Resident Care Coordinator confirmed tenants were to receive safety checks at a minimum of every two hours. During an interview on 10/22/25 at 1:25 p.m., the Registered Nurse (RN) indicated all tenants were to be checked on at least every two hours. According to the RN, if something out of the ordinary happened such as a recent fall, the supervision increased. During an interview on 10/22/25 at 1:15 p.m., the Executive Director confirmed staff should have completed safety checks on all tenants every two hours. The Executive Director pointed out she did not realize the signed occupancy agreements families and tenants signed indicated all tenants received hourly safety checks. During an interview on 10/22/25 at 2:00 p.m., the Executive Director, the RN, and the Resident Care Coordinator confirmed the occupancy agreement information had not matched the service plan information for the four tenants reviewed. The Executive Director, RN, and Resident Care Coordinator confirmed staff had completed two hour checks on tenants and not hourly checks as the occupancy agreement showed.	A 160		
A 315	481-67.7(2)a Waiver of Criteria for Retention 67.7(2) Waiver petition procedures. The following procedures shall be used to request and to receive approval of a waiver from criteria for the	A 315		

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A 315	Continued From page 6 retention of a tenant: a. A program shall submit the waiver request on a form and in a manner designated by the department as soon as it becomes apparent that a tenant exceeds retention criteria pursuant to an evaluation by a health care or human service professional. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the Program failed to submit a waiver request for the retention of a tenant who exceeded care for the Assisted Living Program for People with Dementia. This pertained to 1 out of 4 tenants reviewed (Tenant C1). Finding follows: Record review on 10/21/25, of Tenant C1's record revealed he was placed on hospice on 5/19/25 due to a brain neoplasm. Tenant C1's record revealed the following nurse's notes: a. 7/08/25: The Registered Nurse (RN) documented hospice at the Program to assess Tenant C1. Staff report Tenant C1 required mostly two staff to transfer since a fall on 7/06/25. Pain medication increased and the RN and the hospice RN will continue to monitor. b. 7/11/25: The RN documented a change of condition assessment and new service plan completed. The hospice team reported to the RN, Tenant C1 transitioned to the end of life stage. Tenant C1 was bed bound and required repositioning. Tenant C1 no longer ate food. All medications except for comfort medications were pulled from the medication cart and discontinued. No notations regarding a waiver of the criteria for	A 315	A315 Copper Creek Senior Living does follow the waiver petition procedures. The following procedures shall be used to request and to receive approval of a waiver from criteria for the retention of a tenant. 1. The Regional Nurse, Director and/or Director assignee will apply for the Waiver of Retention when needed. 2. The Regional Nurse, Director and/or Director assignee will make sure the waiver is applied for when there has been a decline in their condition. 3. Director or Director assignee will file the necessary waiver and keep copies of the denial and/or approval in the tenant chart. 4. This was implemented on 10/22/2025.	

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A 315	Continued From page 7 retention of a tenant whose care exceeded what an Assisted Living Program for People with Dementia were noted in the nurse's notes. c. 7/14/25: RN notified on Sunday, July 13, 2025, Tenant C1 passed away. When interviewed on 10/22/25 at 11:36 a.m., the Executive Director reported the Program had not submitted a waiver request for the criteria for retention of a tenant whose care exceeded what an Assisted Living Program for People with Dementia could provide. The Executive Director recalled the administrative team talked about requesting the waiver on 10/11/25 but had not done so. During an interview on 10/22/25 at 2:00 p.m., the Executive Director, the RN, and the Resident Care Coordinator confirmed no waiver was requested by the Program for Tenant C1 who exceeded criteria of retention for an Assisted Living Program for People with Dementia.	A 315		