ok

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 02/23/2026

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: 27 Tenants with cognitive impairment: 12 Total census: 39 Regulatory insufficiencies were cited during the investigation of Incident #130771-I, Complaint #131007-C, and Complaint #131159-C.	A 000	See attached POC 2/23/26	
A 180	481-67.3(6) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(6) To associate and communicate privately and without restriction with persons and groups of the tenant's choice, including the tenant advocate, on the tenant's initiative or on the initiative of the persons or groups at any reasonable hour. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to allow 1 out of 9 tenants to communicate privately with family without restriction (Tenant #3). Finding follows: Record review on 2/19/26, revealed Tenant #3's file indicated an admission date of 8/28/25 with a diagnosis of confusion, malignant neoplasm of	A 180	A180 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 ensure all residents have all access to communication devices. 2. The Regional Nurse, Director, and/or Director assignee will provide education to staff on resident's rights. 3. Director or Director assignee will monitor that all residents' rights are implemented. All staff have been re-educated on resident's rights. 4. This was implemented on 2/23/26.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Regional Director of Operations (X6) DATE: 4/20/2026

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 02/23/2026

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 180	Continued From page 1	A 180		

colon, hypothyroidism, hyperlipidemia, and hypertension. Tenant #3 had no enacted Power of Attorney (POA) or Durable Power of Attorney (DPOA) at the time of the onsite visit. Tenant #3's resident information sheet indicated she had no guardian or POA of health care. She listed her daughters as emergency contacts.

Tenant #3's service plan, dated 1/12/26 and signed by her daughter, revealed the following information regarding personal cares and cognition: Tenant #3 was independent in dressing, toileting, mobility, transfers, and bedmaking. Tenant #3 required stand-by assist for grooming, oral care, and bathing. Tenant #3 received medication administration from staff. Tenant #3's global deterioration score (GDS) was scored at a four which implied moderate cognitive decline. Tenant #3's service plan indicated she was independent in phone usage but staff took her phone after supper each night and gave it back after breakfast each morning. The service plan failed to have Tenant #3's signature to acknowledge her service plan.

Tenant #3's nurse's notes revealed on 12/22/25 a 90 day review completed by the Registered Nurse (RN): Tenant #3 had some confusion on what day it was and what was going on. Tenant #3 showed signs of lack of sleep and anxiety. Tenant #3 was up more often during the overnight hours and called her daughter during those times.

Record review on 2/23/26 of staff communication documentation of tenant observations revealed the following notes regarding Tenant #3 in January 2026 and February 2026:

1/05/26 - Tenant #3 very confused.
1/06/26 - Tenant #3 repeatedly called her

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 02/23/2026

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 180	Continued From page 2 daughter during overnight hours. Staff took her cell phone away per her daughter. When interviewed on 2/23/26 at 12:45 p.m., the Registered Nurse (RN) indicated Tenant #3's cell phone was taken by staff at night and given back to her each morning. When interviewed on 2/23/26 at 10:00 a.m., Tenant #3 reported she was able to call her family independently when she wanted to. When interviewed on 2/23/26 at 1:18 p.m., the Executive Director indicated Tenant #3's phone was taken by staff and placed at the desk for the night. The Executive Director reported Tenant #3 typically came out to ask staff for assistance in calling her daughter at which time, staff gave Tenant #3 her phone back for the day. The Executive Director confirmed the family informed her on 2/23/26 a new placement was secured for Tenant #3 and she was moving to a higher level of care. When interviewed on 2/23/26 at 2:00 p.m., the Executive Director, the RN and the Resident Care Coordinator confirmed staff restricted Tenant #3's ability to communicate with her family during the overnight hours each day.	A 180		
A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in	A 361		

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 02/23/2026

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 361	Continued From page 3	A 361		

accordance with the training provided.

This STANDARD is not met as evidenced by:
Based on observations, interviews, and record reviews, the Program failed to provide services in accordance with the training provided for 2 out of 4 tenants during medication administration (Tenant #7, Tenant #8). Findings follow:

During observations on 2/23/26, a partial morning medication pass was completed by Staff A. During the medication administration pass, the following was observed:

1. At 8:00 a.m., Staff A placed the following medications into a paper medicine cup to administer to Tenant #7: one tablet of Metoprol Suc tab 25 milligrams (mg) ER and one tablet of Metoprolol 25 mg. Staff A went to the breakfast table and handed Tenant #7 the paper medicine cup. Staff A briefly spoke to another tenant at the same table then turned and walked away. Staff A failed to observe Tenant #7 ingest the medications shortly after.

2. At 8:03 a.m., Staff A placed the following medications into a paper medicine cup to administer to Tenant #8: two tablets of Allopurinol 100 mg, one tablet of Aspirin 81 mg, a half tablet of Levothyroxine 112 mg, one tablet of Sertraline 100 mg, and one capsule of Ziprasidone Hydrochloride 80 mg. Staff A went to the breakfast table and handed Tenant #8 the paper medicine cup. Staff A turned and walked away. Staff A failed to observe Tenant #8 ingest the medications.

A review of Registered Nurse (RN) delegations

Provider's Plan of Correction:

A361
Copper Creek Senior Living does follow the staffing and nurse delegation procedures.

1. The Regional Nurse, Director and/or Director assignee will review delegations yearly and as needed.
2. The Regional Nurse, Director and/or Director assignee will keep record of all delegations.
3. Director or Director assignee will ensure that all delegations are on file and up to date.
4. This was implemented on 2/23/26.

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 02/23/2026

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 361	Continued From page 4 on 2/23/26, revealed Staff A was delegated on 10/03/23. The RN delegations section: How to Perform Oral Medication Administration, page five and six revealed Staff A was trained to hand the medication cup to the tenant and make sure the tenant had enough water to take the medication. Also, observe the tenant take the medication, ensuring tenant swallowed the medication completely. When interviewed on 2/18/26 at 1:51 am, Staff A reported she found loose medications on the floor before. Staff A indicated there were some tenants she trusted took their medications and she left the medication cup with them, but other tenants she observed them ingest the pills. When interviewed on 2/23/26 at 12:45 p.m., the RN confirmed Staff should have observed Tenant #7 and Tenant #8 ingest their medications during administration as trained. When interviewed on 2/23/26 at 2:00 p.m., the Executive Director, the RN, and the Resident Care Coordinator confirmed the above findings.	A 361		
A 365	481-67.9(4)g Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall	A 365		

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 02/23/2026

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 365	Continued From page 5 train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to retain staff communication records related to tenant information for all tenants whom resided at the Program. Findings follow: 1. During a review of documents on 2/18/26, the surveyor requested all staff communication documentation regarding daily tenant 1/31/26. A review of staff communication documentation received on 2/19/26, revealed the following records received: November 2025 reflected the staff documentation for the memory care area of the Program. December 2025 reflected no staff documentation received. January 2026 reflected staff documentation for the general population area of the Program. On 2/23/26, February 2026 staff documentation for both the memory care area and the general population area of the Program was received and reviewed. 2. When interviewed on 2/19/26 at 3:00 p.m., the	A 365	A365 Copper Creek Senior Living does follow the staff communication policies. 1. The Regional Nurse, Director and/or Director assignee will ensure all communication sheets are filled out monthly and stored on site for a minimum of three years. 2. The Regional Nurse, Director and/or Director assignee will review communication sheets monthly. The Regional Nurse, Director and/or director assignee will train staff on monthly communication sheets. 3. Director or Director assignee will review all communication sheets monthly and store them in a secure area for no less than 3 years. 4. This was implemented on 2/23/26.	

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 02/23/2026

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 365	Continued From page 6 Executive Director indicated the staff communication documentation for all tenants who lived in the general population area and the memory care area of the Program was not located for the full month of December 2025. The Executive Director provided the November 2025 staff communication notes for the memory care area and January 2026 staff communication notes for the general population area of the Program. During a follow up interview on 2/23/26 at 11:08 a.m., the Executive Director stated only the staff communication documentation for the memory care area was located for November 2025. The staff communication documentation for the general population area of the Program was not located. The Executive Director confirmed the January 2026 staff communication documentation for the memory care area was not located. When interviewed on 2/23/26 at 2:00 p.m., the Executive Director, the Registered Nurse (RN), and the Resident Care Coordinator confirmed the records of staff communication were not retained.	A 365		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception	A 290	A290 Copper Creek Senior Living does follow documentation for each tenant. 1. The Regional Nurse, Director and/or Director assignee will write a nurse's note upon readmit. 2. The Regional Nurse, Director and/or Director assignee will ensure all notes are kept up to date. 3. Regional nurse, Director or Director assignee review readmits monthly. 4. This was implemented on 2/23/26.	

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 02/23/2026

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 290	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to document nurse's notes by exception for 1 out of 9 tenants reviewed (Tenant C1). Finding follows: 1. Record review on 2/18/26, revealed Tenant C1's file indicated an admission date of 7/12/25. Tenant C1's diagnoses included hypothyroidism, type 2 diabetes, hyperparathyroidism, hyperlipidemia, depression, sleep apnea (pediatric), hypertensive heart disease with heart failure, atherosclerotic heart disease, ischemic cardiomyopathy paroxysmal atrial fibrillation, chronic diastolic congestive heart failure, pulmonary fibrosis, acute and chronic respiratory failure, end stage renal disease, and was a smoker. Tenant C1's nurse's notes revealed the following activities documented: 10/21/25 - The Registered Nurse (RN) documented Tenant C1 appeared to have a swollen and painful jaw. Tenant C1 was sent to the emergency room for evaluation. The hospital reported Tenant C1 had elevated white blood cells and an antibiotic was initiated. Tenant C1 was kept overnight at the hospital for observation. 10/22/25 - The RN documented the hospital reported Tenant C1's jaw swelling was down and Tenant C1 was to return to the Program that day with an antibiotic. 10/24/25 - The Resident Care Coordinator documented Tenant C1 pushed her pendant for staff on 10/23/25 at 12:50 p.m. Staff responded	A 290		

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 **02/23/2026**

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 290	Continued From page 8	A 290		

and discovered Tenant C1 laid on her bathroom floor unable to speak. The Resident Care Coordinator noted 911 was called immediately. The Resident Care Coordinator further revealed Tenant C1 passed away before paramedics arrived on the scene. Tenant C1's family requested no autopsy due to her past health history and diagnosis.

Nurse's notes revealed no documentation between 10/22/25 when Tenant C1 returned from the hospital and the notation regarding her death on 10/24/25.

Tenant C1's file further contained an After Visit Summary from the hospital that diagnosed Tenant C1 with left cheek cellulitis/swelling.

2. When interviewed on 2/18/26 at 1:51 p.m., Staff A indicated she worked on the day Tenant C1 returned from the hospital. Staff A reported Tenant C1 stated she was tired but glad to be back. Staff A indicated Tenant C1 immediately went to the smoking area outside of the building to smoke a cigarette when she returned from the hospital. Tenant C1 appeared sluggish but her jaw swelling had receded.

3. When interviewed on 2/18/26 at 3:10 p.m., the RN indicated she assessed Tenant C1 on 10/21/25 when she had a swollen and painful jaw. The RN reported Tenant C1 also showed significant weakness as she struggled to pull her pants up. The RN called the ambulance service to take Tenant C1 to the hospital for evaluation. The RN added the tenant was kept overnight at the hospital for observation and started on an antibiotic. Tenant C1 returned from the hospital on 10/22/25 and staff reported Tenant C1 felt tired but better. On 2/23/26 at 12:45 p.m., the RN

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 02/23/2026

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 290	Continued From page 9 confirmed the Program failed to document Tenant C1's return from the hospital and her condition as a nurse's note by exception. When interviewed on 2/23/26 at 2:00 p.m., the Executive Director, the RN, and the Resident Care Coordinator confirmed the above finding.	A 290		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to address the identified needs and preferences of assistance for 3 of 9 tenants (Tenant #2, Tenant #3, Tenant #4). Findings follow: 1. Record review on 2/19/26, revealed Tenant #2 moved from the general population area of the Program to the memory care area of the Program on 12/15/25. Tenant #2 had a diagnosis of moderate cognitive impairment, a history of falls, hyperlipidemia, hypertension, atrial fibrillation, and long-term usage of anticoagulant medications. Tenant #2's service plan from the general population area of the building dated 9/29/25 revealed the following information regarding toileting: Tenant #2 required staff monitoring, verbal prompts and cues with toileting needs. Staff were to monitor and cue five times daily and	A 395	A395 Copper Creek Senior Living does ensure each service plan identifies their needs and preferences for assistance. 1. The Regional Nurse, Director and.or Director assignee will ensure all nees and preferences are listed on the service plan. 2. The Regional Nurse, Director and/or Director assignee will review service plans when they are completed to make sure everything is accurate and up to date. 3. Regional Nurse, Director and/or Director assignee will make sure all service plans are completed and accurate. 4. This was implemented on 2/23/26.	

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 02/23/2026

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 395	Continued From page 10	A 395		

as needed for toileting.
Tenant #2's service plan from the memory care area of the Program dated 2/18/26 revealed the following information regarding toileting: staff were to monitor and cue Tenant #2 to execute toileting on her own five times daily and as needed.

When interviewed on 2/18/26 at 3:10 p.m., the Registered Nurse (RN) reported Tenant #2 had gone into Tenant #1's apartment at one time and left her underwear in his sink. The RN confirmed Tenant #2 has some behavioral needs of urinating in inappropriate places.

When interviewed on 2/18/26 at 1:51 p.m., Staff A indicated Tenant #1 complained about Tenant #2 going into his apartment in the past. Staff A heard Tenant #2 had a bowel movement and/or urinated in Tenant #1's garbage can.

When interviewed on 2/19/26 at 12:41 p.m., Staff B reported Tenant #2 urinated on the memory care kitchen floor and on the floor in other areas of the memory care. She recalled Tenant #2 urinated and defecated on the floor of the laundry room in the general population area of the Program when she lived on that side.

When interviewed on 2/19/26 at 2:00 p.m., Staff C indicated Tenant #2 had incontinence and would just squat and urinate on the floor in any part of the memory care. Tenant #2 had gone into other tenant's apartments and urinated in their bathrooms too.

When interviewed on 2/19/26 at 2:39 p.m., Staff D reported Tenant #2 was incontinent on the floor and she would squat anywhere when she had to go.

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 02/23/2026

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 395	Continued From page 11	A 395		

Continued From page 11

When interviewed on 2/23/26 at 12:45 p.m., the RN confirmed she completed the service plans. The RN confirmed Tenant #2's service plan failed to address her behaviors of incontinence in inappropriate areas.

2. Record review on 2/19/26, revealed Tenant #3's file indicated an admission date of 8/28/25 with a diagnosis of confusion, malignant neoplasm of colon, hypothyroidism, hyperlipidemia, and hypertension. Tenant #3's service plan, dated 1/12/26 revealed the following information regarding cognition and toileting: Tenant #3 was alert and oriented times three (X3) (person, place, time). Tenant #3 was independent with toileting and had no history of urinary tract infections noted.

Tenant #3's nurse's notes revealed the following documentation:

11/11/25 - Tenant #3 had an increase in anxiety. Tenant #3 was wandering and asking an increase in questions.
12/22/25 - 90 day review completed by the Registered Nurse (RN): Tenant #3 had some confusion on the day and what was going on. Tenant #3 showed signs of lack of sleep and anxiety. Tenant #3 was up more often during the overnight hours and called her daughter during those times.
2/03/26 - Tenant #3 had extreme anxiety in the afternoons, was not sleeping at night and continued to be restless throughout the daytime hours.
2/14/26 - Tenant #3 was attempting to elope. Tenant #3 had hallucinations regarding fire and was screaming. Tenant #3's screaming was

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 02/23/2026

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 395	Continued From page 12	A 395		

disturbing other tenants in the building.
2/15/26 - Tenant #3 sent to the emergency room for assessment and diagnosed with a urinary tract infection. Tenant #3 was prescribed an antibiotic.
2/16/26 - Tenant #3 had visual and auditory hallucinations of fire in the Program. Tenant #3 rushed through the building and banged on other tenant apartments and yelled fire.

Record review on 2/23/26 of staff communication documentation of tenant observations revealed the following notes regarding Tenant #3 in January 2026 and February 2026:

1/05/26 - Tenant #3 very confused
1/06/26 - Tenant #3 repeatedly called her daughter during overnight hours. Staff took her cell phone away per her daughter.
1/07/26 through 1/08/26 - Tenant #3 in and out of Tenant #1's apartment all day. Tenant #1 was upset. Tenant #3 was confused and awake at 3:30 a.m.
1/09/26 - Tenant #3 called 911 scared of another tenant. Tenant #3 was very anxious and scared.
1/16/26- Tenant #3 refused medications and afraid staff were trying to kill her. Tenant #3 tried leaving the building with no shoes on. Tenant #3 believed the air was poisonous in the building.
1/25/26 - Tenant #3 was upset and believed staff tried to poison her. Tenant #3 threw her medication cup with medications in it across the apartment.
1/26/26 - Tenant #3 very confused and not easily redirected.
2/01/26 - Tenant #3 was very confused and exit seeking during the overnight shift. Tenant #3 was convinced the robot vacuum was spraying gas all over and killing everyone.
2/03/26 - Tenant #3 woke up at 2:00 a.m. and believed the building was on fire.

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 02/23/2026

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 395	Continued From page 13	A 395		

2/10/26 - Tenant #3 was panicky all night.
2/11/26 - Tenant #3 was up at 2:00 a.m., yelling help there is a fire!
2/13/26 - Tenant #3 cussed, screamed, and tried to get out the Program door. Tenant #3 tried to wake up other residents and threw things at the resident aide.
2/17/26 - Tenant #3 was upset during two different episodes on the overnight shift and was afraid there was a fire.
2/18/26 - Tenant #3 had a bad night. Tenant #3 tried to exit the building, hit, pushed, and cussed at staff.

When interviewed on 2/18/26 at 2:42 p.m., the Executive Director indicated she was aware Tenant #3 had gone into another tenant's apartment. Tenant #3's anxiety was high and she had been screaming.

When interviewed on 2/18/26 at 3:10 p.m., the Registered Nurse (RN) reported when Tenant #3 first moved in, she displayed some signs of dementia but her anxiety increased and she had hallucinations/delusions, there was fire in the Program. The RN indicated she recently was diagnosed with a urinary tract infection. The family was looking at a higher level of care for Tenant #3 with the encouragement of Program administration. The RN confirmed Tenant #3 went into another tenant's room and woke them up.

When interviewed on 2/18/26 at 1:51 p.m., Staff A indicated she had never observed her go into the apartment. Staff A believed Tenant #3 had also gone into Tenant #1's apartment and upset him. Staff A reported Tenant #3 had been really bad and had been showing her teeth to staff when angry. Staff A Tenant #3 had screamed about fire a lot.

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 02/23/2026

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 395	Continued From page 14 When interviewed on 2/19/26 at 2:39 p.m., Staff D indicated when Tenant #3 first moved into the Program she had no concerns. Several months later, Tenant #3 began having obsessions about fire and the fire was melting her teeth. Staff D caught Tenant #3 bang on the outside of other tenant's doors and yell. Staff D indicated Tenant #3 was independent in personal cares but struggles cognitively. When interviewed on 2/19/26 at 2:53 p.m., Staff E indicated Tenant #3 had hallucinations. Staff E observed Tenant #3 slam chairs, slam doors open, and yell loudly enough to bother other tenants. Staff E indicated Tenant #3 was diagnosed with a urinary tract infection. Staff E caught Tenant #3 in other tenant rooms multiple times yelling until she woke them up. When interviewed on 2/23/26 at 12:45 p.m., the RN confirmed Tenant #3's service plan failed to address her recent treatment of a urinary tract infection and her behaviors regarding hallucinations of fire, yelling, exit seeking, entering other tenant apartments and waking other tenants. 3. Record review on 2/19/26, revealed Tenant #4's file indicated an admission date of 9/22/23 with a diagnosis of dementia, elopement and insomnia. Tenant #4's service plan, dated 1/05/26, indicated the following information regarding eating and toileting: Tenant #4 required no assistance eating meals. Staff to monitor Tenant #4 after meals as he tended to take food and utensils to his room after the meals. No other concerns noted regarding eating. Tenant #4 required staff to monitor and cue Tenant #4 to execute toileting on his own five times daily.	A 395		

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 02/23/2026

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 395	Continued From page 15	A 395		

When interviewed on 2/18/26 at 1:51 p.m., Staff A reported Tenant #4 required a lot of redirection due to him ingesting items. Tenant #4 grabbed items that were not food and ate them. Staff A indicated the other day, Tenant #4 grabbed some of his hair during a haircut and ate it. Tenant #4 also urinated in the kitchen memory care area, kitchen sink and his own bathroom sink.

When interviewed on 2/19/26 at 12:41 p.m., Staff B indicated Tenant #4 urinated in the kitchen sink several times. Staff B added Tenant #4 picked up non-food items and ate them. Staff B observed Tenant #4 took a sponge from the kitchen sink and took a bite from it.

When interviewed on 2/19/26 at 2:00 p.m., Staff C indicated Tenant #4 could have incontinence issues and had urinated in the kitchen once that she was aware of.

When interviewed on 2/23/26 at 12:45 p.m., the RN confirmed Tenant #4's service plan failed to address his behaviors of incontinence in inappropriate places as well as his behavior of eating inedible objects.

When interviewed on 2/23/26 at 2:00 p.m., the Executive Director, the RN, and the Resident Care Coordinator confirmed Tenant #2's, Tenant #3's, and Tenant #4's service plans failed to address all of their identified needs and behaviors.

A 410	481-69.26(4)d Service Plans	A 410		

69.26(4) The service plan shall be individualized and shall indicate, at a minimum:

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 02/23/2026

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 410	Continued From page 16 d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to include a list of person-centered planned and spontaneous activities based on the tenant's abilities for 2 out of 5 tenants reviewed who were unable to plan their own activities or had dementia (Tenant #2 and Tenant #6). Findings follow: 1. Record review on 2/19/26, revealed Tenant #2 moved from the general population area of the Program to the memory care area of the Program on 12/15/25. Tenant #2 had a diagnosis of moderate cognitive impairment, a history of falls, hyperlipidemia, hypertension, atrial fibrillation, and long-term usage of anticoagulant medications. Tenant #2's service plan, dated 2/18/26, indicated the following information regarding cognition: Tenant #2 had a global deterioration score (GDS) of five. A score of five indicated Tenant #2 had moderately severe cognitive decline. Tenant #2 required hourly safety checks daily. Tenant #2 required redirection and supervision to avoid and prevent wandering episodes. Tenant #2's service plan lacked a list of person-centered planned and spontaneous activities based on the tenant's abilities. When interviewed on 2/23/26 at 12:45 p.m., the Registered Nurse (RN) confirmed Tenant #2's	A 410	A410 Copper Creek Senior Living does ensure each service plan is individualized and lists their person-centered planned and spontaneous activities based on their abilities and personal interests. 1. The Regional Nurse, Director and/or Director assignee will ensure person-centered planned and spontaneous activities based on their abilities and interests are on the service plan. 2. The Regional Nurse, Director and/or Director assignee will include spontaneous and personal activities on the service plan. 3. Director or Director assignee review service plans every 90 days or with a change in condition. 4. This was implemented on 2/23/26.	

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 02/23/2026

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 410	Continued From page 17 service plan failed to include a list of person-centered planned and spontaneous activities based on the tenant's abilities. 2. Record review on 2/19/26, revealed Tenant #6's file indicated an admission date of 12/18/25 with a diagnosis of obesity, hyperlipidemia, depression, anxiety disorder, Alzheimer's disease, insomnia, sleep apnea, carpal tunnel syndrome, hypertension, male erectile dysfunction, and solitary pulmonary nodule. Tenant #6's service plan, dated 1/13/26, indicated the following information regarding cognition: Tenant #6 had a global deterioration score (GDS) of four. A score of four indicated Tenant #6 had moderate cognitive decline. Tenant #6 required hourly safety checks daily. Tenant #6 required redirection and supervision to avoid and prevent elopement. Tenant #6's service plan lacked a list of person-centered planned and spontaneous activities based on the tenant's abilities. When interviewed on 2/23/26 at 12:45 p.m., the Registered Nurse (RN) confirmed Tenant #6's service plan failed to include a list of person-centered planned and spontaneous activities based on the tenant's abilities. When interviewed on 2/23/26 at 2:00 p.m., the Executive Director, the RN, and the Resident Care Coordinator confirmed the above findings.	A 410		