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
	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

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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. Number of tenants without cognitive impairment: 21 Number of tenants with cognitive impairment: 5 Total census: 26 The following regulatory insufficiencies were cited during the investigation of Complaint #129246-C and Complaint #129601-C.	A 000		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure physician's orders were carried out for 2 of 8 current tenants reviewed (Tenant #4 and Tenant #5). Findings follow: 1) Record review on 8/4/25 revealed a	A 285		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 285	Continued From page 1 Comprehensive Assessment for Tenant #5, dated 5/16/25. At the time of the assessment, Tenant #5 experienced 4+ edema. The indentation was 6-8 mm, which could last up to 2-5 minutes. She was noted to have mild cognitive impairment which required some direction and reminding from others. Tenant #5's 5/16/25 service plan identified she had an order from her provider for TED hose or Ace Wraps. In regard to the TED hose or Ace Wraps, the service plan directed the care specialists: please assist with putting them on and taking them off. Staff completed a 24-hour report on 7/20/25 which indicated the skin on Tenant #5's lower left and right legs was red. A note from 7/23/25 documented staff had to go to Tenant #5's apartment multiple times on 7/23/25 to remind her to attend meals. An Emergency Room (ER) physician's note dated 7/23/25 identified Tenant #5 presented in the ER at 2:31 PM. Her daughters reported she'd experienced confusion since the previous night along with bilateral leg swelling and redness. She had some pain in her right lower leg. The ER physician reviewed Tenant #5's medical history which included diagnoses of chronic venous insufficiency, chronic kidney disease and hypertension. He did not think volume overload was the cause of her leg swelling. The ER physician recommended mechanical compression and stressed the need for this. He prescribed an antibiotic four times daily for five days to treat cellulitis. He stressed the importance of close outpatient follow-up with her primary care provider (PCP). The Health and Wellness Coordinator (HWC)	A 285		

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A 285	Continued From page 2	A 285		

documented on 7/24/25 at 9:32 AM she received a report from the hospital ER nurse on 7/23/25 Tenant #5 would be returning to the building with new orders for Cephalexin four times daily and to wear compression stockings as discussed. She faxed the orders to the pharmacy. Tenant #5 returned to the building at 5:45 PM on 7/23/25.

A review of the Medication Administration Record (MAR) for Tenant #5 for July, 2025 revealed an entry was added for Ted hose, two times per day. Apply TED hose every morning and remove in the evening. This entry was added to the MAR on 7/26/25, 3 days after Tenant #5's return from the hospital. Staff documented the administration of the Cephalexin as follows:
7/23/25 at 8:43 PM - did not administer
7/24/25 at 10:00 AM - administered
7/24/25 at noon - no entry
7/24/25 at 4:00 PM - no entry
7/24/25 at 8:32 PM - administered
The Cephalexin was administered as prescribed on 7/25/25 and 7/26/25.

A progress note on 7/26/25 documented Tenant #5 went to the ER to be seen for continued leg swelling.

Emergency Documentation dated 7/26/25 noted Tenant #5 presented at the ER for increased bilateral leg swelling. Her daughter stated the redness spread up her legs and the swelling was worse. The physical exam noted her bilateral lower extremities were swollen, erythematous and painful to palpation. She was on Cephalexin since 7/23/25, although there was a slight gap in treatment due to the program not being able to give doses until the evening of 7/24/25. Given her worsening redness, swelling and altered

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mental status, she would likely benefit from inpatient admission for IV antibiotics. Tenant #5 was diagnosed with cellulitis of both lower extremities. She was discharged on 7/30/25 to a nursing facility. At the time of discharge she continued to complain of some calf pain and tenderness which was likely attributed to the inflammation and infection of the bilateral legs.

On 8/7/25 at 8:25 AM Tenant #5's daughter reported in the week leading up to the first visit to the ER she noticed swelling in her mother's legs. She went to visit her mother on 7/25/25 and Tenant #5 did not have compression stockings on. When the daughter asked the aides about this they did not know Tenant #5 was supposed to be wearing compression stockings. The daughter spoke with the Executive Director (ED) who stated a nurse had to add compression stockings to the MAR and this had not been done as the building did not have a nurse. She asked the ED to get it added to the MAR immediately.

On 8/5/25 at 4:00 PM Tenant #5's other daughter/Power of Attorney (POA) recalled she went to pick her mother up for an eye doctor appointment on 7/23/25 and discovered her legs were red and quite swollen. She was surprised no one from the program had contacted her to report this. Tenant #5's children decided it would be best to take her to the ER rather than the eye doctor. The ER doctor stated the tenant had the beginning of cellulitis and prescribed an antibiotic. He said the only way to help with the fluid build-up was for Tenant #5 to wear compression stockings and elevate her legs. He made it clear to her what needed to be done was for her mom to wear the compression stockings. When she returned her mother to the building

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A 285	Continued From page 4 neither the nurse or ED were present. She told the staff member working her mother needed to take the prescribed antibiotic and to wear compression stockings. The POA got her mom fitted for the compression stockings on 7/24/25 and dropped them off at the building after work in the afternoon. She gave the stockings to staff and asked if the antibiotic had been delivered and it had not. The POA was troubled because her mother did not receive a dose of the antibiotic until the evening of 7/24/25 even though she asked repeatedly if she could get it from a local pharmacy (so it would be delivered quickly) rather than from the program's out of town pharmacy. The POA had to work on 7/25/25 and did not see her mother that day. When she went to the building on 7/26/25, her mother's legs were significantly worse due to swelling, redness and blistering. Her mom said no one put her to bed the previous night. She was dressed in the clothing from the previous day. She did not have her compression stockings on. Her mother was in the hospital for 4 days. She was really weak upon her discharge from the hospital and was dragging her foot. During an interview on 8/11/25 at 1:50 PM Staff D reported she was administering medication to tenants on 7/24/25. She remembered there was an issue with administering Tenant #5's antibiotic on 7/24/25, but could not recall what it was. Either the antibiotic was not present or it was not listed on the MAR. She was not sure if she administered the medication. Staff G did remember being glad when she learned Tenant #5 was going to start on an antibiotic because her legs were in bad shape and she was confused.	A 285		

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A 285	Continued From page 5 Staff E was interviewed on 8/11/25 at 2:15 PM and stated when she encountered Tenant #5 the morning of 7/26/25 her legs were very red and swollen. She did not know prior to that day Tenant #5 was to wear the compression stockings, so she did not put them on the tenant that morning. On 8/5/25 at 3:50 PM the Vice President of Clinical Services reported it was possible the HWC did not realize Tenant #5 would get her TED hose so quickly and this was the cause of the delay in adding the order to the MAR. 2) Record review on 7/29/25 revealed a 24-hour note dated 7/16/25 identifying Tenant #4 had some discomfort in between the legs. A progress note from the Nurse Practitioner (NP) dated 7/17/25 identified she was seen for an acute visit due to complaints of burning, urgency and frequency with urination during the past couple of days. The NP ordered a urine analysis. She encouraged adequate hygiene, toileting every two hours to avoid incontinence and increased oral intake. The HWC documented the order from the NP on 7/18/25 at 8:10 AM. There were no other notes about Tenant #4's urinalysis in the record. The MAR did not indicate she was started on an antibiotic. During an interview with the Vice President of Clinical Services on 8/5/25 at 1:10 PM she reported the staff had been trying to get the urine sample since 7/18/25 without any luck. Staff A was interviewed on 8/5/25 at 1:50 PM and	A 285		

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A 285	Continued From page 6 reported she was not aware of the need to obtain a urine sample from Tenant #4 until 8/1/25. She tried to get the sample repeatedly on that date without success. Staff A assumed other staff were able to get the sample until she heard from a nurse on 8/5/25 it was still needed. Staff B was interviewed on 8/5/25 at 1:55 PM and said she did not know a urine sample was needed from Tenant #4 until 7/31/25. Staff C stated during an interview on 8/5/25 at 3:40 PM she did not know about the order for a urine sample until 8/1/25. She told the ED Tenant #4 was itching in the vaginal area a few weeks ago and then did not hear anything else about it. During an interview on 8/5/25 at 4:30 PM the Vice President of Clinical Services confirmed the urine sample for Tenant #4 was submitted to the lab on 8/5/25, more than two weeks after the order was written.	A 285		
A 325	481-67.9(1) Staffing 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide tenants at the program the necessary nursing and caregiving assistance required to meet the needs identified in their service plans, potentially affecting all tenants.	A 325		

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A 325	Continued From page 7 Findings include, but are not limited to: 1) A. Record review on 8/4/25 revealed Tenant #5's 5/16/25 service plan which identified she had an order from her provider for TED hose or Ace Wraps. The service plan directed the care specialist: please assist with putting them on and taking them off. Staff completed a 24-hour report on 7/20/25 which indicated the skin on Tenant #5's lower left and right legs was red. An Emergency Room (ER) physician's note dated 7/23/25 identified Tenant #5 presented in the ER at 2:31 PM. Her daughters reported she'd experienced confusion since the previous night along with bilateral leg swelling and redness. She had some pain in her right lower leg. The ER physician reviewed Tenant #5's medical history which included diagnoses of chronic venous insufficiency, chronic kidney disease and hypertension. He did not think volume overload was the cause of her leg swelling. The ER physician recommended mechanical compression and stressed the need for this. He prescribed an antibiotic four times daily for five days to treat cellulitis. He stressed the importance of close outpatient follow-up with her primary care provider (PCP). The Health and Wellness Coordinator (HWC) documented on 7/24/25 at 9:35 AM she received a report from the hospital ER nurse on 7/23/25 Tenant #5 would be returning to the building with new orders for Cephalexin four times daily and to wear compression stockings as discussed. She faxed the orders to the pharmacy. Tenant #5 returned to the building at 5:45 PM. A note in the 24-hour report indicated staff had to go to Tenant #5's room multiple times on 7/23/25 to remind her	A 325		

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A 325	Continued From page 8 to attend meals. A review of the Medication Administration Record (MAR) for Tenant #5 for July, 2025 revealed an entry was added for Ted hose, two times per day. Apply ted hose every morning and remove in the evening. This entry was added to the MAR on 7/26/25, 3 days after Tenant #5's return from the hospital. Emergency Documentation dated 7/26/25 noted Tenant #5 presented at the ER for increased bilateral leg swelling. Her daughter stated the redness spread up her legs and the swelling was worse. The physical exam noted her bilateral lower extremities were swollen, erythematous and painful to palpation. She was on Cephalexin since 7/23/25, although there was a slight gap in treatment due to the program not being able to give doses until the evening of 7/24/25. Given her worsening redness, swelling and altered mental status, she would likely benefit from inpatient admission for IV antibiotics. Tenant #5 was diagnosed with cellulitis of both lower extremities. She was discharged on 7/30/25 to a nursing facility. At the time of discharge she continued to complain of some calf pain and tenderness which was likely attributed to the inflammation and infection of the bilateral legs. On 8/7/25 at 8:25 AM Tenant #5's daughter reported in the week leading up to her mother's first visit to the ED she noticed swelling in her legs. She went to visit her mother on 7/25/25 and Tenant #5 did not have compression stockings on. When the daughter asked the aides about this they did not know she was to wear compression stockings. The daughter spoke with the Executive Director who stated a	A 325		

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nurse had to add compression stockings to the MAR and this had not been done as the building did not have a nurse. She asked the Executive Director to get it added to the MAR immediately.

On 8/5/25 at 4:00 PM Tenant #5's daughter/Power of Attorney (POA) recalled she went to pick her mother up for an eye doctor appointment on 7/23/25 and discovered her legs were red and quite swollen. She was surprised no one had contacted her to report this. Tenant #5's children decided it would be best to take her to the ED rather than the eye doctor. The doctor stated the tenant had the beginning of cellulitis and prescribed an antibiotic. He said the only way to help with the fluid build-up was for Tenant #5 to wear the compression stockings and elevate her legs. He made it clear to her what needed to be done was for her mom to wear the compression stockings. When she returned her mother to the building there was no nurse or executive director present. She told the staff working her mother needed an antibiotic and the compression stockings. The POA got her mom fitted for the compression stockings on 7/24/25 and dropped them off at the building. She gave the stockings to staff and asked if the antibiotic had been delivered. The POA was troubled because her mother did not receive a dose of the antibiotic until the evening of 7/24/25 even though she asked repeatedly if she could get it from a local pharmacy rather than from the program's out of town pharmacy. The POA had to work on 7/25/25 and did not see her mother then. When she went to the building on 7/26/25, her mother's legs were 100% worse due to swelling, redness and blistering. Her mom said no one put her to bed the previous night. She was dressed in the clothing from the previous

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day. The POA pressed the emergency pendant to call for staff assistance for her mother and no one arrived for 30 minutes.

During an interview on 8/11/25 at 1:50 PM Staff D reported she was administering medication to tenants on 7/24/25. She remembered there was an issue with administering Tenant #5's antibiotic on 7/24/25, but could not recall what it was. Either the antibiotic was not present or it was not listed on the MAR. She was not sure if she administered the medication. Staff G did remember being glad when she learned Tenant #5 was going to start on an antibiotic because her legs were in bad shape and she was confused.

During an interview on 8/11/25 at 2:25 Staff E reported the power was out for a period of time in the building on 7/26/25 and she did not respond to Tenant #5's page for almost an hour. She did not know anything about the need for her to wear compression stockings. Tenant #5's legs were really red and swollen. She called the Executive Director after Tenant #5 went to the hospital and got the task of assisting with the stockings on the task sheet.

On 8/5/25 at 3:50 PM the Vice President of Clinical Services reported it was possible the HWC did not realize Tenant #5 would get her TED hose so quickly and this was the cause of the delay in adding the order to the MAR.

B. Staff were to complete 24-hour logs with information about tenants who had a change of condition such as new orders, an injury, skin problems, pain or anything unusual. A review of 24-hour logs revealed the following entries from

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staff:
- On 6/22/25 Tenant #10 was not feeling good and staff gave him cold medication. On 6/23/25 he was coughing a lot and staff gave him cold medication again.
- Staff were to check on Tenant #8 every 15-30 minutes on 6/26/25.
- An undated entry (possibly 6/26/25) identified Tenant #1, Tenant #10 and a third tenant all had coughs.
- On 6/28/25 and 6/29/25, Tenant #8 and another tenant had a bad cough. They did not leave their rooms all day.
- Tenant #10 had a fall with a skin tear on his left arm on 7/15/25. Staff were instructed to change the bandage as needed.
- Tenant #7 had a wound on his left buttock from a fall on 7/16/25.
- On 7/20/25, Tenant #5's lower left and right legs were red but did not hurt or itch.
- Tenant #1 had the start of a pressure sore on her outer left ankle on 7/22/25.

C. Tenant #7 had a pre-admission assessment completed virtually on 4/25/25. He had a history of Type 2 diabetes, neuropathy and anxiety. He had wounds on his bilateral heels. The nurse documented the left heel wound had white eschar tissue at the wound base and wound edges were pink. The right heel had a dark wound bed. It was difficult to assess due to the virtual assessment.

D. Tenants and staff reported during interviews they wished there was a nurse available in the building to discuss their medical concerns:
- On 7/29/25 at 11:05 AM Tenant #10 said she experienced issues with constipation. The medication passer administered a stool softener

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but it was not helping. Then she met with a NP in the building who told her she had as needed medications such as Milk of Magnesia or Miralax on her MAR which staff could have offered. This was not ever mentioned to her. She thought if there was a nurse in the building to discuss this with, she might have had relief sooner.
- On 8/5/25 at 3:15 PM Tenant #7 discussed due to the wounds on his feet, cellulitis and other pain he had experienced since moving in, it would have been nice to review these issues with a nurse. Tenant #7 shared he would like to start physical therapy but did not know who to discuss this with.
- During interviews on 7/28/25 and 8/11/25 Staff D stated it was clear there was no nurse in the building. Staff don't receive clear direction in providing care to the tenants. There was a lack of communication between staff and the direction staff did receive kept changing. She gave the example of when she received training on administering medication one employee taught her it was okay to leave medication in tenant's apartments if they were not present so they could take it upon their return. She was later instructed this was not okay. Staff D was told by the ED she should discontinue medication for a hospice patient even though they had not received an order to do so and the medication was still listed as active on the MAR. The tenant ended up displaying anxiety later in the day, perhaps as a result of not receiving her anxiety medication. Staff D has seen the HWC once since the former nurse left (on 6/9/25).
- On 8/6/25 at 2:05 PM Staff F stated she has not seen a nurse in the building for a couple of months.
- Staff E reported on 7/29/25 at 4:05 PM she has not seen a nurse in the building for about two

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A 325	Continued From page 13 months. They call the HWC if they need something. - On 7/29/25 at 8:35 AM Staff A said she had worked in the building for about two months. She met with a nurse when she was delegated and had not seen one since that time. E. The programs' Occupancy Agreement Addendum A of included services identified there would be nurse availability for supervision. On 7/29/25 at 1:30 PM the Executive Director (ED) reported the HWC conducted virtual assessments of tenants. The previous nurse left on 6/9/25 and a nurse from a sister building, approximately 79 miles away, took over. The HWC reportedly started coming to the building once a week at the end of June, 2025, although the Director was unable to provide the dates of the visits. The ED stated she called the nurse daily and faxed incident reports to her. She did not provide the HWC with copies of the 24-hour logs so the nurse was not aware when tenants had changes in health. There were some situations, such as the tenants who were experiencing coughs, where they had the tenants see the NP when she visited once a week. 2) A. A monthly task log for the month of June identified Tenant #5 was to receive housekeeping one time weekly on Saturday. She received it 3/4 Saturdays in June. In July, staff cleaned her apartment 2 of 4 weeks out of the months. Tenant #5 was dependent on staff to wash, dry, fold and put away her laundry. They were to do this once a week. In June, staff completed the task 3/4 times per month and in July, 2 of 5 times per month. Staff were to help her with bathing twice weekly. This task was completed 6 of 9	A 325		

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A 325	Continued From page 14 times in June. On 6/5/25, an employee documented she did not help Tenant #5 with a bath as there were "not enough staff". Staff assisted Tenant #5 with bathing 5 of 8 opportunities in July. B. Record review on 8/4/25 of a monthly task log revealed Tenant #1 was to receive weekly housekeeping. Staff cleaned her apartment 2 weeks out of 4 in June, 2025 and 3 weeks out of 4 in July, 2025. Staff were to perform her laundry every week and did so each week in June, 2025 and 2 weeks out of 4 in July, 2025. Tenant #1 had service plans dated 5/28/25 and 6/27/25 which noted she required moderate assistance with bathing, which included assistance with cueing and assistance getting in/out of the shower. She had bathing assistance 3 times in June but no times in July. During an interview on 8/5/25 at 2:45 PM Tenant #1 reported she had received 1 shower or less a week for months. She did not know her service plan indicated she was to receive two showers a week. Tenant #1 wasn't sure if she received weekly housekeeping but did not believe the service was performed thoroughly. She gave the example of recently getting sick and vomiting on her bedding and the carpeting in her bedroom. Staff changed her bedding and cleaned up the mess on her floor, however there was still a stain on the carpet. There used to be a housekeeper and she believed that person would have brought in a spot cleaner to sanitize the carpet. Tenant #1 reported experiencing a number of falls and worried staff would not respond promptly if she suffered a serious injury due to the lack of staffing.	A 325		

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A 325	Continued From page 15 C. Record review on 8/4/25 of a monthly task log revealed Tenant #4 required assistance with bathing, such as getting in and out of the shower on Monday and Saturday. The hospice aide would provide additional bathing service twice weekly. Staff were to provide Tenant #4 with 9 showers in June, but only gave her 2 showers. Staff assisted her to bathe 5 of 8 times in July, 2025. D. During an interview on 7/29/25 at 10:40 AM Tenant #6 stated she complained to the ED a number of times about concerns regarding a lack of staffing and chores not getting done. She was supposed to get a shower on 7/28/25 and no one showed up to give her one. Tenant #6 had a concern about the number of staff available as there was only one person staffed in the front of the building. When she pushed her pendant for assistance, staff were supposed to respond in fifteen minutes but it could take longer. There were times no one responded. There were other times she had to wait 30 minutes for staff to respond to her page. When interviewed on 7/29/25 at 11:05 AM, Tenant #9 said the staffing situation seemed bad. The staff did all they could, but can't manage it all. She's had to push her pendant a few times and they usually came pretty quickly but one time it took them 20 minutes to show up. She was supposed to get showers twice a week and they were trying to ensure this happened, but they didn't always do so. Tenant #9's medication was administered by staff. She was supposed to get one morning pill by 7:30 AM, before she went to breakfast and about half the time they delivered it after 8:00 AM. Things were pretty good when	A 325		

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A 325	Continued From page 16 she moved in but her services have declined. On 7/29/25 at 1:00 PM Tenant #8 was interviewed and reported his biggest concern was "the help". Sometimes he did not receive a shower as often as he should and other times he got his medication late. His bathroom did get cleaned twice a week. Staff usually responded to pages within 15 minutes but last week he pushed and pushed his pendant and no one showed up. There was a strong odor of urine in Tenant #8's apartment. During an interview with Staff D on 7/28/25 at 2:25 PM she reported they were often short staffed which resulted in things getting missed like tenants not getting showers, apartments not getting cleaned, medications being administered late and pendants not being answered within 15 minutes. They no longer have a housekeeper so the Med Tech was responsible for administering medication, doing laundry, serving meals, doing housekeeping and providing cares to 21 tenants. On 7/28/25 at 4:05 PM, Staff E stated she often covered the front of the building caring for 21 tenants by herself. When she covered the front, she might not finish the evening medication pass until 9:20 PM - 9:40 PM when she was supposed to be finished by 9:00 PM. There were times she was called to the secured memory care unit to assist with a tenant due to her aggression. Staff E might not get started with showers until 8:40 PM. When she was trying to care for the tenants, there were times the trash didn't get taken out or the laundry didn't get done. They were down to only two working dryers which was a problem as well (2 were broken).	A 325		

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A 325	Continued From page 17 During an interview with the Executive Director on 7/29/25 at 1:30 PM she reported there was no reason for tenants to miss their showers or receive their medication late. She believed there was an appropriate number of caregiving staff to meet tenants' needs. The program had a Staffing Requirements policy which noted the community would ensure sufficiently trained staff would be available at all times to fully meet tenants scheduled and unscheduled or unpredictable needs in a manner that promotes maximum dignity and independence and provides supervision, safety and security. There were no specific staffing ratios required, but staffing levels would be adequate to meet the needs of the tenants. The community would ensure the assisted living program was overseen by a Registered Nurse (RN). The RN would be responsible for the overall management of resident care and ensuring compliance with all applicable regulations. During an exit meeting with the Regional Director of Operations on 8/11/25 at 2:45 PM she did not dispute the findings.	A 325		
A 160	481-69.23(1)c(1) Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or	A 160		

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A 160	Continued From page 18 displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review the program admitted and retained 1 of 1 tenants reviewed admitted within the past two months despite them displaying physical and verbal aggression (Tenant #2). Findings follow: Record review on 8/5/25 revealed an admission packet for Tenant #2. She had a Preadmission Screening and Resident Review completed on 6/16/25 indicating she was appropriate for a nursing facility. Tenant #2 briefly lived at a nursing facility (6/19/25 - 6/25/25) before moving to the assisted living program. A review of progress notes from the nursing facility revealed the following: - On 6/20/25 at 8:33 PM staff documented Tenant #2 had an increase in behaviors after dinner which included yelling at staff/people present, cursing, attempting to swing her arm at others, threw dishes off tables and threw coffee on the floor after asking for it. Staff attempted redirection three times without a change in behavior. She continued to speak in circles with foul language and the Primary Care Provider (PCP) was notified and a one time dose of Haldol was ordered. After she took the medication her wandering decreased, but not the behaviors. She did mistake a chair for the restroom and the nurse was able to intervene before any issue occurred. - On 6/21/25 at 7:25 PM Tenant #2 presented with multiple behaviors. She became agitated and aggressive when wandering and was diverted by staff and fellow residents. She threw	A 160		

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A 160	Continued From page 19	A 160		

a cup at another resident resulting in the cup striking a visitor. She was administered a one-time dose of Haldol. Multiple attempts were made throughout the shift to redirect Tenant #2 to quieter and calmer areas with varying results. Staff worked with her 1:1 for about 30%-40% of the shift.
- Tenant #2 was up a couple of times overnight on 6/23/25 at 1:03 AM entering other residents' rooms. She tended to become aggressive when around large groups of residents. She spit out two pills on this date.

Tenant #2 moved to the program on 6/25/25. A review of progress notes, incident reports, PCP notes and hospital discharge summaries revealed the following:
- A hospital discharge summary dated 6/25/25 identified Tenant #2 was there due to issues with dementia and anxiety.
- A progress note from the Nurse Practitioner (NP) identified Tenant #2 went to the Emergency Room (ER) yesterday for uncontrolled behaviors.
- On 6/26/25 at 9:00 PM an incident report identified Tenant #2 came out of her room without pants on and urinated on the floor. Staff helped her to put pants on which she removed and then urinated on the floor again. She was threatening and yelling at others.
- An incident report dated 6/26/25 at 10:00 PM noted Tenant #2 came out of her apartment stating everyone was going to hell. She grabbed a broom and threw it at a tenant and staff. Tenant #2 threatened to kill anyone she got her hands on. 911 was called and an ambulance transported Tenant #2 to the ER. She returned on 6/27/25 at 1:20 AM and removed her pants and attempted to urinate in a chair. She refused to put pants back on.

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A 160	Continued From page 20 - A progress note from the NP on 7/3/25 identified Tenant #2 was urinating and defecating on the floor outside of her room. She would try to enter other tenants' rooms and when redirected would become agitated and aggressive with staff. She was started on Seroquel with some improvement noted but could still be difficult to redirect. Tenant #2 was noted to have behaviors in the middle of the night. - A hospital discharge summary indicated Tenant #2 was discharged from the ER on 7/5/25 due to dementia with agitation and a urinary tract infection. - Staff had to remove activity supplies from the common area according to an incident report dated 7/8/25 at 8:00 PM because Tenant #2 was ripping them up and throwing them. She also tried to eat sponges and colored pencils. - An incident reported dated 7/11/25 noted Tenant #2 screamed after putting herself on the floor on 7/11/25 at 10:30 PM. When staff tried to get her up she got aggressive and tried to hit staff. A hospital discharge summary gave instructions Tenant #2 may require a higher level of care than what an assisted living program was able to provide. - On 7/14/25 at 5:45 PM an incident report documented Tenant #2 was upset and in her room. She threw her shoes at a staff member. About five minutes later Tenant #2 screamed and was found face down on the floor. She had a cut on her head. Staff called 911 and she was transported to the hospital. - A progress note from 7/16/25 identified she was walking around the dining room threatening to kill tenants. She then threw chairs across the room and entered others' apartments. 911 was called and she was transported to the hospital.	A 160		

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A 160	Continued From page 21 Staff D was interviewed on 7/28/25 at 2:25 PM and reported Tenant #2 had physically attacked tenants and staff. At the time of the interview it was taking two staff to provide toileting assistance because she would kick and punch when the care was provided. Staff D felt as if they were unable to provide Tenant #2 with the care she needed due to her level of aggressiveness. On 7/28/25 at 4:05 PM, Staff E reported Tenant #2 required 2-3 staff to assist with cares at times due to her level of violence. The day Tenant #2 moved to the building she threatened to stab staff and tenants with a fork. There were times additional staff were needed to provide incontinence cares as she was soaking wet and trying to kick them. During an interview with Staff F on 8/6/25 at 2:05 PM she said it took 2-3 staff to provide toileting assistance to Tenant #2. Each time she was provided incontinence cares Tenant #2 was physically aggressive. This was a problem from the time she moved in to the present. It did not seem to matter what approach was taken with the tenant or which staff member was working. The Vice President of Clinical Services (VP) was interviewed on 8/7/25 at 2:20 PM and reported Tenant #2 was calm when the Health and Wellness Coordinator completed her initial assessment virtually. The VP helped Tenant #2 to get dressed and did not have problems. She believed with staff training and continued medication adjustments, Tenant #2 would be appropriate for assisted living. She said it was appropriate to admit her to the program based on the Health and Wellness Coordinator's	A 160		

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A 160	Continued From page 22 assessment.	A 160		
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 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to document nurses' notes by exception for 3 of 8 current tenants reviewed (Tenant #2, Tenant #5 and Tenant #7). Findings follow: 1) Record review on 8/4/25 revealed the following discharge summaries, incident reports and nurse practitioner (NP) notes for Tenant #2: - A NP progress note dated 6/26/25 identified Tenant #2 went to the emergency room on 6/25/25 for uncontrolled behaviors. The program had a hospital discharge summary dated 6/25/25 identifying Tenant #2 visited the Emergency Room (ER) due to anxiety and dementia. There was no nursing note documenting this incident. - An incident report dated 6/26/25 noted Tenant #2 came out of her room, threw a broom at staff and tenants and threatened to kill anyone she got her hands on. Staff called 911 and an ambulance transported her to the hospital. She returned from the hospital at 1:20 AM on 6/27/25.	A 290		

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A 290	Continued From page 23 There was not a nursing note documenting this incident. - A discharge summary dated 7/5/25 revealed Tenant #2 visited the hospital on 7/5/25 due to dementia with agitation and a urinary tract infection. There were no nursing notes about this hospital visit. - Discharge instructions from 7/12/25 noted Tenant #2 went to the hospital due to dementia with agitation. The program progress notes provided no information about this. 2) Record review on 8/4/25 revealed a NP note for Tenant #5 dated 6/3/25. She had a history of macular degeneration and was recently given an eye injection. She was seen by the NP for follow-up of eye pain post-injection. Tenant #5 experienced significant eye pain following injections administered by her opthamologist on 5/28/25. Upon returning from her appointment, she reported severe eye pain, prompting a one-time verbal order to administer scheduled Tylenol immediately and hold the 8:00 PM dose. The nurse reported the intervention was effective and no request for a change or additional dose of Tylenol was made. The patient reported her pain was resolved. There was no nursing note about the 5/28/25 incident. 3) Record review on 8/6/25 of the 24-hour log revealed the following entries involving Tenant #7: - Staff documented on 7/16/25 Tenant #7 had a wound on his left buttock from a fall last night. - On 7/26/25 it was noted he had a lot of pain in both legs. His wife is going to take him to the hospital. There were no nursing notes about these entries involving Tenant #7.	A 290		

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A 290	Continued From page 24 On 8/11/25 at 11:30 AM the Regional Director of Operations reported the Executive Director did not report many of these pieces of information to the Health and Wellness Coordinator. She confirmed the program failed to document nurse's notes by exception.	A 290		
A 370	481-69.26(3)a 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. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to update the service plans of 3 of 8 current tenants reviewed (Tenant #2, Tenant #7 and Tenant #3) and 1 of 1 discharged tenants reviewed (Tenant C1) who experienced a significant change of condition. Findings follow: 1) Tenant #2 was admitted to the program on 6/25/25. A service plan developed on that date identified she had no history of mood or depression issues. A Comprehensive Assessment dated 6/25/25 noted tenant #2 had a current or history of aggressive or socially inappropriate behavior, either verbally or physically. The plan noted she needed bowel and bladder assistance, but did not note any	A 370		

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A 370	Continued From page 25 inappropriate urination. It was identified in the Service Plan Tenant #2 did not have a history of urinary tract infections. She hadn't experienced falls in the previous 90 days. A review of Tenant #2's record revealed the following: - A hospital discharge summary dated 6/25/25 identified Tenant #2 was there due to issues with dementia and anxiety. - A progress note from the Nurse Practitioner (NP) identified Tenant #2 was admitted to the memory care unit from a long-term care facility. She went to the Emergency Room (ER) yesterday for uncontrolled behaviors. - On 6/26/25 at 9:00 PM an incident report identified Tenant #2 came out of her room without pants on and urinated on the floor. Staff helped her to put pants on which she removed and then urinated on the floor again. She was threatening and yelling at others. - An incident report dated 6/26/25 at 10:00 PM noted Tenant #2 came out of her apartment stating everyone was going to hell. She grabbed a broom and threw it at a tenant and staff. Tenant #2 threatened to kill anyone she got her hands on. 911 was called and an ambulance transported Tenant #2 to the Emergency Room (ER). She returned on 6/27/25 at 1:20 AM and removed her pants and attempted to urinate in a chair. She refused to put pants back on. - A progress note from the NP on 7/3/25 identified Tenant #2 was urinating and defecating on the floor outside of her room. She would try to enter other tenants' apartments and when redirected would become agitated and aggressive with staff. She was started on Seroquel with some improvement noted but she could still be difficult to redirect. Tenant #2 was noted to have	A 370		

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	S0280	A. BUILDING: _____ B. WING _____	C 08/11/2025

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A 370	Continued From page 26	A 370		

behaviors in the middle of the night.
- A hospital discharge summary indicated Tenant #2 was discharged from the ER on 7/5/25 due to dementia with agitation and a urinary tract infection.
- Staff had to remove activity supplies from the common area according to an incident report dated 7/8/25 at 8:00 PM because Tenant #2 was ripping them up and throwing them. She also tried to eat sponges and colored pencils.
- An incident report dated 7/11/25 noted Tenant #2 screamed after putting herself on the floor on 7/11/25 at 10:30 PM. When staff tried to get her up she got aggressive and tried to hit. A hospital discharge summary gave instructions Tenant #2 may require a higher level of care than what an assisted living program was able to provide.
- On 7/14/25 at 5:45 PM an incident report documented Tenant #2 was upset and in her room. She threw her shoes at a staff member. About five minutes later Tenant #2 screamed and was found face down on the floor. She had a cut on her head. Staff called 911 and she was transported to the hospital.
- Tenant #2 had a fall in her room on 7/15/25 without injury. When assisted up, she told staff she wanted to kill them.
- A progress note from 7/16/25 identified she was walking around the dining room threatening to kill tenants. She then threw chairs across the room and entered others' apartments. 911 was called and she was transported to the hospital.

The program nurse did update Tenant #2's service plan on 7/25/25, long after she displayed multiple events of aggression requiring emergency intervention, urinated in inappropriate places, tried to eat items which were not food, experienced falls which caused injury and had a

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A 370	Continued From page 27 urinary tract infection. 2) Record review on 8/6/25 revealed Tenant #7 had a service plan dated 6/27/25 which noted he needed skin care due to eczema and wounds to his bilateral heels. He was able to express pain but there was no mention of the location of his pain. A review of Tenant #7's record revealed the following information: - The nurse spoke with him on 7/8/25 about inappropriate conversations he was having with staff. He verbalized understanding. - He tripped while trying to plug in his motorized scooter on 7/16/25, landing backwards on his rear end. A note in the 24-hour log notified the nurse he had a wound on the left buttocks from a fall the previous night. - The NP met with Tenant #7 on 7/17/25 about pain in his right knee. She prescribed Diclofenac gel every 6 hours as needed. He was to report any new or uncontrolled pain to the nursing staff. Nursing staff were to report any signs of uncontrolled or new pain to his Primary Care Provider (PCP). - Staff documented in the 24-hour log Tenant #7 was in a lot of pain on 7/26/25 and went to the hospital. Tenant #7's service plan did not identify he may have inappropriate conversations with staff or interventions on how staff should respond. There was no mention of skin conditions or pain related to Tenant #7's buttocks or knee. 3) Record review of a service plan for Tenant #3 dated 5/15/25 identified she required extensive assistance from staff with mobility. She was	A 370		

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known to get up on her own and did not always use her walker. Staff were to remind Tenant #3 to use her walker and ask for assistance.

An interview was conducted with Tenant #3's hospice nurse on 8/5/25 at 2:00 PM. He reported Tenant #3 was able to stand up, but was unable to walk. Tenant #3 utilized a wheelchair for mobility purposes.

During an interview on 8/6/25 at 2:05 PM Staff F reported Tenant #3 was able to stand for transfers but was not using a walker. Staff transported Tenant #3 to the bathroom, dining room and common areas in her wheelchair.

The program did not update Tenant #3's service plan when she had a change of condition affecting her mobility.

4) Record review on 7/29/25 of Tenant C1's 4/9/25 service plan identified he wished to maintain or maximize his current level of functioning with toileting. He wore adult briefs and required prompting 4+ times per day with toileting. A comment was added to the plan on 3/29/25 under behavior: Tenant encouraged to use bathroom for toileting needs.

A review of progress notes revealed the following entries:
- Tenant was reported to have increased agitation during the evening shift on 5/2/25. He had several episodes of incontinence.
- Tenant C1 was helped to the restroom on 5/11/25 and when assisted back to the common area he proceeded to pull his pants down and defecate on a chair. When staff helped him back to the restroom to clean up he became agitated

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A 370	Continued From page 29 and struck staff in the head. - An incident report dated 6/15/25 noted Tenant C1 tried to urinate on the furniture and in the hallway five times during the overnight shift. He would pull his pants down and yell for help to pull them up. The program failed to update Tenant C1's service plan to address his public urination and defecation. During an exit meeting on 8/11/25 at 2:45 PM the Regional Director of Operations and Vice President of Clinical Operations confirmed the program failed to update tenants' service plans when their needs changed.	A 370		