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 01/20/2026

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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. Tenants without cognitive impairment: 26 Tenants with cognitive impairment: 5 Total census: 31 No regulatory insufficiencies were cited during the investigation of Incident #130859-I. The following regulatory insufficiencies were cited during the investigation into Complaint #130319-C, #130358-C, #130378-C, #130354-C, #131042-C and #131152-C.	A 000		
A 130	481-67.2(1)e Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to complete an incident report when 1 of 12 current tenants reviewed went to the emergency room (Tenant #9). Findings follow: Record review on 1/20/26 of notes from the	A 130		

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

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A 130	Continued From page 1 emergency department revealed on 11/26/25 Tenant #9 moved to the program one to two days earlier. She was very aggressive to staff and called her daughter over 100 times. Staff sent her to the emergency department as they could not manage her behavior. During a review of incident reports one was not located for the event with Tenant #9 on 11/26/25. The Regional Director of Services provided all incident reports on 12/30/25. An incident report detailing the situation which occurred with Tenant #9 was not present. On 1/21/26 at 12:57 PM the Vice President of Clinical Services confirmed she added the incident report to Tenant #9's record in January, more than a month after the situation occurred.	A 130		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to follow policies related to medication administration affecting 2 of 12 current tenants (Tenant #1 and Tenant #9) and 1 of 2 discharged tenants (Tenant C1). Findings follow: 1. Record review on 12/29/25 revealed the program had inpatient discharge instructions for Tenant C1 dated 12/04/25. Scheduled	A 150		

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medications following her hospital discharge included: Aspirin, Furosemide, Metoprolol, Nystatin powder, Spironolactone and Warfarin (1 mg 6 days weekly, 2 mg each Friday).

The Registered Nurse (RN) sent a fax to Tenant C1's Primary Care Provider (PCP) on 12/04/25 noting Tenant C1 and her daughter would like to continue with the Warfarin, Metoprolol and Spironolactone. The nurse questioned if it was ok to continue with the plan as the tenant returned from the hospital on hospice care and took her medication crushed in puree. The fax sheet was signed by the PCP on 12/05/25 and a stamp on the bottom of the form noted "received/faxed to pharmacy 12/10/25 at 2000". The stamp was signed by the RN.

A review of Tenant C1's December Medication Administration Record revealed the following:
-Metoprolol was administered beginning on 12/12/25.
-Nystatin was administered beginning on 12/12/25.
-Spironolactone was administered beginning on 12/13/25.
-Warfarin 2 mg was administered only on 12/12/25 (Friday).
-Warfarin 1 mg administered on 12/05/25 (Friday), 12/13, 12/14, 12/15 and 12/16 .

A review of a Hospice Plan of Care dated 12/04/25 noted medication would be managed and administered by the Program. Tenant C1 would continue on Warfarin. All medication orders and changes would be provided to the Executive Director. The Hospice nurse became aware the Program discontinued Tenant C1's medication on 12/10/25 but should not have

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occurred. The Hospice nurse met with the RN who stated Tenant C1 was not receiving her medication as it was discontinued by Hospice. The Hospice nurse told her this was not correct. The RN reportedly then stated the hospital must have stopped the medication. The RN said she would be happy to start the medication if she received medication orders to do so. The RN then told the Hospice nurse Tenant C1 was taking her Warfarin (the program only administered one dose as of 12/10/25).

2. Record review on 12/31/25 of a Hospice notebook with entries made by family, Program staff and Hospice workers revealed the following entries:
- On 11/27/25, Tenant #5 was noted to be developing a bed sore on her tailbone.
- A hospice Licensed Practical Nurse (LPN) documented on 12/01/25 awareness of a stage 1 pressure ulcer to the top of her coccyx. She sought an order for Calazinc cream, to be applied twice daily and as needed.
- On 12/09/25 Tenant #5's granddaughter noted the sore on her buttock was open and bleeding. When wiping her, she asked staff to apply the cream on the wipe.
- A hospice nurse documented Tenant #5's wound was healing and no longer open on 12/18/25. She applied the barrier cream.

There was no barrier cream or similar medication on Tenant #5's December, 2025 MAR.

An interview conducted with the Health and Wellness Director (HWD) on 12/31/25 at 2:09 p.m. revealed Hospice staff brought barrier cream into the building to treat a wound on Tenant #5's buttocks. Staff administered the

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medication even though it was not on the MAR. She sent the order to the pharmacy so it would be added to the MAR.

3. Record review of a January, 2026 MAR for Tenant #1 revealed she received medication 1/01/26, 1/02/26, and 1/03/26. There was a gap on the MAR until January 6th and ongoing.

An interview conducted with Staff E on 1/07/26 at 1:10 p.m. revealedTenant #1 moved from the secured memory care unit to the assisted living portion of the building over the weekend. When Tenant #1 made this move, her medication list was no longer available on the Program's electronic MAR system. Staff E administered medication to Tenant #1 from the pill cards in her cabinet, but without an approved list to review to ensure what she administered was correct.

During an interview on 1/07/26 at 3:40 p.m. the Health and Wellness Director confirmed Tenant #1's medications were not available on the electronic MAR for some shifts over the weekend. She tried to get staff a paper MAR when she learned of the problem, but this may not have been available to everyone.

4. Record review of progress notes for Tenant #9 revealed she moved to the Program on 11/24/25. She resided in the secured memory care unit. That evening the RN was called to the unit as Tenant #9 yelled, "Let me out of here!". She attempted to leave the building for several hours. The RN contacted Tenant #9's PCP and received a verbal order for an intramuscular (IM) injection of Lorazepam. The injection was administered and she began to calm down.

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A 150	Continued From page 5 An incident reported dated 12/04/25 documented Tenant #9 fell on the floor when getting into bed. She did not require medical treatment. An incident report from 12/05/25 noted the afternoon of 12/04/25, Tenant #9 was more lethargic and sleepy. It continued through the morning of 12/05/25. PRN, or as needed, Haloperidol as well as Lorazepam hadbeen administered. No other abnormal behavior was noted. Tenant #9 stated she did not feel right. She was transported to the hospital for an evaluation. Review of a Final Report from Tenant #9's hospitalization (from 120/5/25 - 12/09/25) revealed she presented with lethargy and a fall. The patient had been aggressive with a behavior change. It seemed as if Tenant #9 was being overmedicated at the nursing facility. She was on Haloperidol as well as Lorazepam. Her daughter believed the patient was being given these medications as a preventative strategy even before she got excessively agitated. Upon discharge, Tenant #9's PRN IM Haldol and Lorazepam were discontinued. HerPRN medication of 5 mg Haldol, 2 mg Lorazepam and 0.5 mg Lorazepam were also discontinued. During an interview on 1/06/26 at 2:00 p.m. the Executive Director reported giving Tenant #9 IM injections but reported she was fairly new to the building and was not able to make entries in the computer system. When entries needed to be made, the RN needed to do this for her. A review of the November, 2025 and December, 2025 MARs for Tenant #9 revealed the Lorazepam injection was administered on 11/30/25 and 12/05/25. There was no documentation of Lorazepam being administered	A 150		

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A 150	Continued From page 6 on 11/24/25. There was no documentation of the Haldol injection being administered, as indicated in the 12/05/25 incident report. A Controlled Drug Record sheet noted Staff F administered 0.5 mg. of PRN Lorazepam to Tenant #9 on 12/10/25 at 2:00 p.m. and on 12/11/25 at 12:00 a.m., after the medication was discontinued. On 1/07/26 at 10:39 a.m. the HWD reported in an interview she discontinued Tenant #9's medication, including the 0.5 Lorazepam on 12/10/25 at 8:38 a.m.. Staff F should have known not to administer this medication on 12/10/25 and 12/11/25 when looking at the MAR. A review of the Program's Medication Management policy noted each administration of medication must be documented in the tenant's medication administration record, including the date, time, dosage and name of the staff member administering the medication. Medication orders must be documented in the tenant's record. If staff was unable to document on a tenant's MAR, a licensed nurse could record administration of medication in the progress notes.	A 150		
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.	A 160		

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A 160	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the Program failed to provide services according to 6 of 12 current tenants and their families (Tenant #3, Tenant #4, Tenant #7, Tenant #9, Tenant #10, Tenant #13) and the family of 1 of 2 discharged tenants (Tenant C1). Findings follow: 1. Record review on 12/29/25 revealed Tenant C1 was an 87-year old woman diagnosed with heart failure, cardiomegaly, pulmonary hypertension, bacteremia, chronic kidney disease stage 3, dysphagia and colostomy. Tenant C1 ' s service plan, dated 9/25/25 indicated she maintained her skin independently but was at risk for skin breakdown. She had a small healing open area to the right shin. She was to inform staff of any changes or signs of infection. A review of progress notes revealed on 10/20/25, the Registered Nurse (RN) documented orders were received for Tenant C1 to take Cephalexin (an antibiotic) twice daily for 10 days. She also needed dressing changes to the open areas on her leg. A non-adherent pad should be applied to open areas, wrapped with gauze to assist with the weeping. Tubigrips were placed over her wrapped legs. These should be changed twice daily or as needed if soiled. Skin checks were to occur when changing the dressings to the legs. The antibiotic was sent to the Program's pharmacy. Tenant C1's daughter was going to purchase the dressing supplies. The RN noted on 10/23/25 staff used some dressing supplies from the medication room and what the tenant	A 160		

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had in her room to dress Tenant C1's bilateral legs. There was more seeping from her left lower extremity than from the right lower extremity. Both lower legs were very edematous with pitting in the 3+ areas. She tolerated the dressing changes well. Staff on duty watched the dressing changes. The dressing changes were added to the EMAR on 10/24/25. Staff documented providing the dressing changes twice daily from 10/24/25 to11/09/25 (with the exception of 11/09/25 in the AM when Tenant C1 refused the treatment).

On 11/03/25 Tenant C1's daughter met with the RN and expressed she was concerned the Primary Care Provider (PCP) was not doing enough to address the edema and her shortness of breath. Her mother was unable to walk to the dining area without stopping one to two times to sit and catch her breath. The RN called the PCP's office and received a return call on 11/04/25. The PCP ordered testing and a cardiology consult. The testing revealed fluid around the tenant's lungs so he increased her Lasix. If the tenant's shortness of breath increased over the weekend, she should go to the emergency room. Tenant C1 called the RN reporting increased shortness of breath. Her daughter was going to take her to the emergency room.

During interviews with Tenant C1's daughter on 12/29/25 and 1/06/26 she reported when her mother's legs started filling up with fluid, staff were supposed to wash them, apply wrappings and the tubigrips. They needed to do this because her mother was unable to bend over and complete the task herself. Staff were to do this twice daily. Sometimes staff would apply the

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tubigrips and sometimes they would not. They had a meeting about concerns with this and the delay in staff response time when her mother needed assistance. For instance, her mother waited 45 minutes for someone to come and get her off the toilet following an episode of diarrhea. Tenant C1 did not only go to the hospital for shortness of breath but also due to gaining 35 pounds of fluid, according to her daughter. Tenant C1's pants did not fit her and she went up two sizes. She also developed urinary incontinence during this period.

Staff C was interviewed on 12/30/25 at 1:45 p.m. and recalled Tenant C1 reported her legs felt as if they were burning prior to going to the hospital in November. Staff C told the RN about this. The RN showed about six employees how to put Tenant C1's tubigrips on and then they were to demonstrate it to the other employees. Tenant C1 told her there were two employees who cut off her circulation when they put on the tubigrips. Staff C entered the apartment and saw her legs very small, red at the ankle and quite large at the top. The bandages had a dark, mucus color on them where the sores leaked through.

When interviewed on 12/31/25 at 10:55 a.m. Staff D reported Tenant C1 asked to have her tubigrips on all the time. When she applied new bandages she noted a lot of fluid leaking out of the tenant's legs. She assumed the nurses knew about this. Staff D reported it to the oncoming shift and those employees said they told the RN.

B. On 11/09/25, Tenant C1 presented at the Emergency Department (ED) with increased shortness of breath and bilateral lower extremity edema. She was admitted to the hospital for IV

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(intravenous) Lasix and fluid restriction. While hospitalized, she saw wound care for multiple pressure areas. She was found to be bacteremic with enterococcus. Tenant C1 had a chest x-ray performed which showed bilateral pleural effusions consistent with fluid overload. She then aspirated and another chest x-ray was performed showing worsening congestive heart failure. Prior to hospitalization, she was independent with activities of daily living. Due to her significant decline in the hospital and poor response to treatment, hospice was consulted. She was discharged from the hospital back to the Program. Assessment at the Program revealed the ostomy was functioning. She had a foley catheter which was in place. There was a wound to the coccyx and a skin tear to the left arm. Tubigrips were in place to her bilateral lower extremities. Her appetite was poor and she was mainly drinking protein drinks and eating ice cream. Tenant C1 needed intermittent assistance with feeding. She was on a pureed diet with thickened liquids and took her medication crushed in applesauce. Medications were reconciled with Tenant C1's PCP and would be managed by the Program. She was on bed rest.

A Hospice nursing note from 12/08/25 identified when the nurse arrived she found Tenant C1's catheter leaked. The ostomy was intact and functioning. She assisted with a bed bath as Tenant C1 was a two person assist. She removed the tubigrips from Tenant C1's legs and indents and redness were noted behind her knees. She called out in pain when the red area caused by the tubigrip was cleaned. The Hospice nurse spoke with staff after the visit and let them know the catheter leaked. She informed them to

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let her know if the catheter leaked again. They denied having any questions.

The Hospice nurse met with Tenant C1 on 12/10/25. The ostomy bag did not have a clamp on it. Tenant C1 said a nurse came in the previous evening and clamped it improperly. She tried to tell the Program staff how to do it the right way but the person would not listen. The Hospice nurse noticed Tenant C1 was saturated with urine and there was feces on her blanket and ostomy. Staff assisted with bringing in a new blanket and pad for the bed. The RN then asked how often Hospice would be providing baths to Tenant C1 as the program would not be providing this service when Hospice was doing it. The RN shared Tenant C1 was not receiving medication, other than Warfarin, as it was discontinued when she discharged from the hospital. The Hospice nurse let the RN know the medication was not discontinued and would follow up with the doctor about this. A review of Tenant C1's EMAR revealed Tenant C1 received one dose of Warfarin on 12/05/25. Her other medication did not start until 12/12/25.

The Hospice nurse and bath aide arrived on 12/11/25 to complete a bed bath and bed change. Tenant C1's catheter was leaking again. Her peri area was red with a white discharge noted. The Hospice nurse contacted the PCP for orders to address the discharge. The Hospice nurse again asked staff to let her know if the catheter was leaking.

The Hospice team had a meeting with Tenant C1's PCP on 12/11/25. They discussed concerns the program was unable to meet her needs. They increased home health visits to five per week due

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to concerns of the catheter leaking and a reddened peri area. The RN contacted the Hospice nurse and informed her she received the medication orders and medicine would be administered when delivered (it was not administered until 12/12/25). Hospice nursing visits were increased to daily to ensure personal cares were met and medications were being given. The Hospice nurse met with the Executive Director to discuss her concerns related to medication, the tenant being found saturated in urine from head to toe and the clamp on the colostomy bag missing with stool on the patient and bedding. The Executive Director reported it was unacceptable and would hold a meeting with staff to ensure Tenant C1 was cared for the way she deserved.

The Hospice nurse visited on 12/12/25 with no concerns. On 12/15/25 when the Hospice nurse arrived she learned from the Health and Wellness Director (HWD) Tenant C1 received a complete bath and bed change in the morning as she was saturated in urine. The ostomy bag was emptied prior to her arrival.

When the Hospice Home Health Aide (HHA) arrived on 12/16/25, she found Tenant C1 laying sideways in bed and very confused. Her incontinence pad was saturated with urine and/or discharge from her bottom. Program staff came to assist her with cares. The HHA asked staff how often they were checking on Tenant C1. They informed her they were unable to reposition her every two hours due to low staffing and Tenant C1 requiring a two-person assist. They discussed Tenant C1's level of confusion as this was unusual. Staff reported she was hallucinating through the night but they had not

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administered any medication to assist with this. Tenant C1's mouth was dry and crusted over. Staff were not feeding Tenant C1, reportedly as they were not certified to do so. She reported pain with repositioning. The HHA provided catheter, incontinence and peri-cares. Staff were unable to provide any clean linen. The HHA placed a clean bath sheet under Tenant C1 until clean sheets were provided. The coccyx wound appeared to have a greenish discharge which was new. Staff stated they were unaware of how to care for the wound and asked for information on how to do so.

Two Hospice nurses returned to visit Tenant C1 the afternoon of 12/16/25 and found her clean but gasping for air. Lunch was sitting beside her. Tenant C1 said she ate half a grilled cheese and some ice cream. They pressed the call light and waited 30 minutes for a response. The HWD arrived and they discussed concerns about medication, repositioning and the deterioration of the wound. They asked the HWD why she did not mention Tenant C1 was not receiving medication and was having issues swallowing medication when they met on 12/15/25. The HWD said she saw on 12/16/25 Tenant C1 missed some medication. The Hospice nurses reported they were initiating Morphine due to Tenant C1's shortness of breath and pain. The HWD returned with two staff who wanted education on how to give these medications. The Hospice team later spoke with Tenant C1's daughter about a transfer to the Hospice House due to concerns about the program.

Tenant C1 and her daughter decided she would move to the Hospice House on 12/17/25. She did leave the program on that date.

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A 160	Continued From page 14 A Hospice nurse was interviewed on 12/29/25 at 12:22 p.m. She reported Tenant C1 was admitted to hospice on 12/04/25. A big concern of hers was the ability of staff to safely reposition and bathe Tenant C1 while she was in bed. This could be scary as she was a larger lady and the task required a two-person assist. It could be dangerous if only one person did it and she was afraid Tenant C1 would fall out of bed. The Hospice nurse provided a list of services which the program did not provide adequately: - the discharge medication list was not correct - medication was not administered for several days - Tenant C1 was not checked frequently. She would expect someone who was bed-bound to be checked every two to three hours. - The ostomy bag was not closed. - Staff were alerted if there were problems with the ostomy or catheter to call Hospice but this was not done. - Medications were not administered from the comfort kit. - Staff reported they were not certified to feed Tenant C1 so she did not receive nourishment. - They put fungal cream intended for her wound on the peri area. - It did not appear wound care was completed as ordered. Tenant C1's daughter interviewed on 12/29/25 at 6:03 p.m. reported the RN evaluated her mother prior to her discharge from the hospital and was aware she was bed-bound and required two people for repositioning. The Executive Director assured the daughter they had more staff and would be able to meet her needs. The daughter called the RN when she learned her mother was	A 160		

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not receiving her medication. She was told there was confusion with the pharmacy and no one knew the Program was to administer the medication. She recalled going to her mother's apartment and finding cups staff left everywhere. Staff would leave grilled cheese sandwiches and soup at her bedside. The daughter did not understand why this was done if her mother was choking on pills. They provided her mother with 20 ounce tumblers she could not handle and short straws which fell into the cup. The daughter bought sippy cups which the program lost. Things were bad on 12/16/25. When she talked with the new HWD she did not seem to know what medication her mother took or if her mother was swallowing her pills. The Executive Director reportedly stated she did not know there were problems related to her mother's care.

During an interview on 12/29/25 at 1:10 p.m. Staff G reported it took two staff to reposition or turn Tenant C1. They had to turn her in bed every two hours and she was unable to do this by herself. There were times she worried Tenant C1 would fall off the side of her bed as it was small and the tenant was a larger lady. They put a wedge under Tenant C1, but were unable to put her on her side. They tried to do everything they could, but there was only one staff during the nighttime shift and Tenant C1 could not be repositioned with only one employee. She did not recall seeing Tenant C1's catheter bag leaking but did know her coccyx wound was leaking a green substance. Staff G reported staff were not allowed to feed tenants at the program due to concerns of aspiration. She knew Tenant C1 had difficulty swallowing and would even gag if she tried to feed herself. For this reason, Staff G would bring food into Tenant C1 and leave it at

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A 160	Continued From page 16 her bedside. Staff E interviewed on 1/06/26 at 10:15 a.m., recalled the first time she tried to give Tenant C1 a pill she refused it. Staff E offered to give the pill to her in applesauce but the tenant said no. The pill was not crushed. She shared with Hospice staff Tenant C1 choked on her medication. In an interview on 12/31/25 at 10:55 a.m. Staff D reported it required two people to safely reposition Tenant C1 in bed as she was a big lady. When she worked at night, the employee covering the secured memory care unit was not able to assist with this task so she had to do it by herself. 2) Record review on 12/31/25 of a History and Physical revealed Tenant #4 carried diagnoses of Diabetes mellitus Type 2, obesity, chronic kidney disease stage III, central cord syndrome, cervical canal stenosis, neurogenic claudication, wheelchair dependent; hypertension and history of foot ulcers and wounds. The RN documented in a progress note on 11/19/25 Tenant #4 went for a podiatry appointment on 11/18/25 and received new orders for a dressing to the right heel daily, protect with gauze and tape or a band aid. Keep the area clean and dry. She faxed the order to the pharmacy and added this to the EMAR. The HWD assessed Tenant #4's lower left extremity on 12/22/25 and noted he had redness and multiple open areas with serous drainage. He reported severe pain to the area if touched. She also assessed an open area to his inner left 5th toe.	A 160		

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A 160	Continued From page 17 A History and Physical dated 12/23/25 indicated Tenant #4 presented at the hospital due to a black discoloration at the tip of his left fifth toe without pain in his foot. He also had black discoloration to his right heel. An MRI of the left foot showed signs of osteomyelitis of the left fifth toe (a bone infection). He was also diagnosed with cellulitis. During the course of his hospitalization Tenant #4 chose to have an amputation of his left small toe rather than go through a prolonged course of IV antibiotics. This surgery was conducted on 12/26/25. Tenant #4 discharged from the hospital and returned to the program on 1/06/26. During an interview on 12/30/25 at 1:45 p.m. Staff C reported Tenant #4's leg began hurting the week before Thanksgiving after he slid off a chair. The pain increased after that time. Tenant #4 did not want to get his weight taken daily. Tenant #4 was out of his Hydrocodone and this was a medication the nurse had to refill. She reported this to the HWD and Executive Director who directed her to administer Acetaminophen. She recalled reporting to the RN on her last day in the building Tenant #4 was in so much pain he couldn't even stand. Staff A was interviewed on 12/31/25 at 10:15 AM. She applied lotion to Tenant #4's knees and put a bandage on his heel daily when she administered his medication. Staff A did not notice issues with his heel. She did notice throughout the month of December Tenant #4 had a skin tear on his leg which seemed to be getting worse. His legs also seemed to be getting bigger and redder. She was not sure if this was related to him retaining fluid or putting on weight. Staff A said his condition did not concern her enough; she thought it needed to	A 160		

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A 160	Continued From page 18 be reported to the nurse. In an interview with Staff E on 1/06/26 at 10:15 a.m. and 1/13/26 at 2:20 p.m. she recalled seeing Tenant #4's legs when they were red and reporting it to the RN. Staff E applied lotion to Tenant #4's legs and also put bandages on his heel, both daily. His heel looked calloused, but not black. When she put the bandage on Tenant #4's heel he requested she not remove his sock as it was hard to put on and hurt. When she noticed the sores on Tenant #4's were leaking (on 12/22/25), she notified the HWD who immediately assessed his condition. Staff E remembered Tenant #4 asked her for his pain medication, Hydrocodone, in December, but it was not available as they ran out of the pills. She asked the nurse to request a refill but this did not occur. The Vice President of Clinical Services reported on 1/13/26 and 1/14/26 staff received training upon hire and during the first and second weekend of December about how to reorder pain medication, such as Hydrocodone, for tenants so they don't run out. During an interview with the HWD on 1/07/26 she reported when staff were applying a bandage to a tenant's heel they should remove his sock, assess for changes and report if there was a change or the tenant voiced a change. Staff members should have notified the RN or HWD when Tenant #4's leg was red, painful and had sores. 3) Record review on 1/07/26 revealed December, 2025 and January, 2026 Device Activity Reports which provided information on the length of time	A 160		

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it took staff to respond after a tenant pushed their emergency response pendant for assistance.

a.Tenant #7 had a history of transient ischemic attack (TIA) and cerebral infarction based on her face sheet. The Device Activity Reports noted when Tenant #7 pressed her pendant for assistance in December, it took staff more than 15 minutes to respond on 41 occasions. The longest response time was 45 minutes. During the period of 1/01/26 - 1/05/26, there were five occasions it took staff more than 15 minutes to provide Tenant #7 with assistance. The longest period of time to respond was fifteen minutes.

During an interview on 1/05/26 at 11:20 a.m. Tenant #7 reported she used to be more independent. However, since she had a stroke, she couldn't get up and go to the bathroom on her own as she was unable to move her foot and had to wait for staff to walk her to the toilet. In addition, she had to use the bathroom more since having the stroke. An observation of Tenant #7 revealed she used a walker and required standby assistance from staff when ambulating due to an unsteady gait.

b. A review of the Device Activity Report indicated Tenant #13 pushed her pendant for assistance and had to wait over 15 minutes for assistance on 27 occasions in December. The longest wait time was 50 minutes. She pushed her pendant six times in January, with the longest wait being 41 minutes.

Tenant #13 reported she was 102 years old. She would push her pendant for assistance when she fell or needed assistance getting to the bathroom. There were times she had to wait for staff to help

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her but they did their best. She did wish staff would be better about cleaning her apartment as there were times it could be three to four weeks when there was no housekeeping.

c. A review of incident reports revealed the following:
- On 12/03/25 at 8:30 a.m. staff documented Tenant #4 reported a fall from his recliner after his legs became weak. The Device Activity Report indicated he pushed his pendant for help at 8:16 a.m. It took staff 23 minutes and 19 seconds to respond.
- On 12/23/25 at 10:00 a.m. staff noted Tenant #15 was attempting to pick up a paper from her floor and lost her balance. Information from the Device Activity Report revealed she pressed her pendant for help at 9:42 a.m. when it took 16 minutes and 38 seconds for a response.

During an interview with the Executive Director and the HWD on 1/7/26 at 3:45 p.m., they reported concerns over pendants not being answered in a timely manner. The Executive Director reviewed the Device Activity Report on a weekly basis. She confirmed staff were having a difficult time responding to pendants in a timely manner when there were only two employees working in the building. On 12/29/25 at 9:19 a.m.the Executive Director reported the goal was for staff to respond to pendants within 10 minutes or less. Any time over 10 minutes was concerning to her.

4. Record review of progress notes for Tenant #9 revealed she moved to the Program on 11/24/25. She resided in the secured memory care unit. That evening the RN was called to the unit as Tenant #9 was yelling "Let me out of here!". She

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attempted to leave the building for several hours. The RN contacted Tenant #9's PCP and received a verbal order for an intramuscular (IM) injection of Lorazepam. The injection was administered and she began to calm down.

An incident reported dated 12/04/25 documented Tenant #9 fell on the floor when getting into bed. She did not require medical treatment. An incident report from 12/05/25 noted the afternoon of 12/04/25, Tenant #9 was more lethargic and sleepy. It continued through the morning of 12/05/25. PRN Haloperidol as well as Lorazepam were administered. No other abnormal behavior was noted. Tenant #9 stated she did not feel right. She was transported to the hospital for an evaluation.

Review of a Final Report from Tenant #9's hospitalization (from 12/05/25 - 12/09/25) revealed she presented with lethargy and a fall. The patient was aggressive with a behavior change. It seemed as if Tenant #9 was being overmedicated at the nursing facility. She was on Haloperidol as well as Lorazepam. Her daughter believed the patient was being given these medications as a preventative strategy even before she got excessively agitated. Upon discharge, Tenant #9's PRN IM Haldol and Lorazepam were discontinued. Her PRN medication 5 mg Haldol, 2 mg Lorazepam and 0.5 mg Lorazepam were also discontinued.

A Controlled Drug Record sheet noted Staff F administered 0.5 mg. of PRN Lorazepam to Tenant #9 on 12/10/25 at 2:00 p.m. and on 12/11/25 at 12:00 a.m., after the medication was discontinued.

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A 160	Continued From page 22 On 1/07/25 at 10:39 AM the Health and Wellness Director reported in an interview she discontinued Tenant #9's medication, including the 0.5 Lorazepam on 12/10/25 at 8:38 a.m.. Staff F should have known not to administer this medication on 12/10/25 and 12/11/25 when looking at the MAR. During an interview with Tenant #9's daughter on 1/07/25 at 10:49 a.m. she reported her mother's first two weeks at the program were rough. Her mother was hospitalized thirty-six hours after her admission. Her mother was calling her all the time, she heard through the phone staff were putting her in an ambulance and sending her to the hospital. The daughter thought about bringing her mother home at that time. The ED doctor let her know the first month could be difficult and the family should wait it out. A week after this, there was another hospitalization. Her sister went to visit Tenant #9 and their mother was very tired. The next day her mother could not hold up a glass or even dress herself. They decided to take her to the ED. They believed she was over medicated. The ED doctor said the staff could only administer the medication which was ordered, so upon discharge most all "as needed" or PRN medication was discontinued. Her biggest concern was related to overmedication. 5. Record review of Tenant #3's face sheet on 12/31/25 revealed she had diagnoses of intervertebral disc degeneration, fracture of the left pubis with delayed healing, wedge compression fracture of the first lumbar vertebra and lumbago with sciatica. Tenant #3's December, 2025 MAR listed she was prescribed Hydrocodone/Apap tablets, 5-325 mg, as needed three to four times a day. The December	A 160		

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A 160	Continued From page 23 MARs revealed 1-3 days gaps when Tenant #3 was not administered Hydrocodone/Apap tablets, 5-325 mg. On other dates, she received the medication 1-4 times daily. The dates are as follows: December 2 - December 3 and December 10 - December 12. Tenant #3 interviewed on 12/30/25 at 9:55 a.m. stated she moved to the program after experiencing fractures on both sides of her pelvis. She was also having problems with her vertebrae. These issues cause her a lot of pain. Tenant #3's biggest issue at the program was when she missed her medication. She reported one weekend she went from Friday to Monday without her pain medication. Tenant #3 felt as if she went through withdrawal and was in a lot of pain. The only times she pressed her pendant was when she needed medication due to pain. Once she waited 40 minutes for staff to come and assist her. On 12/29/25 she did not receive her medication until 11:00 p.m. because the pharmacy did not deliver it until this time. When interviewed on 12/30/25 at 1:45 p.m., Staff C indicated Tenant #3 had Hydrocodone/Apap which she could take "as needed" and she would request it often. When the medication needed reordered, she would inform the RN of this. Tenant #3 reported her symptoms of being sick to her stomach and having a headache when she did not have her medication. In an interview on 12/31/25 at 10:15 a.m. Staff A reported Tenant #3 became upset when she did not receive her Hydrocodone/Apap. She asked for the medicine non-stop. When that specific medication wasn't available, it caused significant problems for Tenant #3.	A 160		

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A 160	Continued From page 24 Staff E was interviewed on 1/06/25 at 10:15 a.m. reported the program ran out of Hydrocodone/Apap tablets for Tenant #3 several times. They would notify the nurse when the tenant was running low on pills but they did not seem to get reordered right away. During an interview with Staff D on 12/31/25 at 10:55 a.m. she recalled working once when Tenant #3 ran out of her Hydrocodone/Apap. The medication arrived the next day. Tenant #3 stated she really needed the medicine. Staff D administered the tenant Tylenol instead of the prescribed medication. The Vice President of Clinical Services provided logs of calls made from the RN and her to pharmacy on 11/13, 11/14, 11/17, 12/5, 12/10, 12/11, 12/12, 12/14. These calls did not result in Tenant #3 having Hydrocodone/Apap as needed. 6. During a tour of the building with the Executive Director on 12/29/25 at 9:45 AM Tenant #10's apartment was found to have a strong urine smell throughout the rooms. Soiled clothing was found laying on the floor under the sink. The Executive Director reported the tenant kept his soiled clothes there for staff to pick up and wash. The floor in the bathroom was tacky, causing one's shoes to stick to the floor. Upon leaving the apartment, the Executive Director reported a care conference was held to determine methods to keep the tenant's apartment clean. Prior to the meeting the smell of urine reached into the hallway. His family had a recliner in the unit professionally cleaned and the program started cleaning the floor with stronger	A 160		

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A 160	Continued From page 25 products and cleaning/checking the bathroom more frequently. A review of Tenant #10's service plan, dated 10/02/25 indicated he was to receive housekeeping and laundry services once daily. Staff were to help him with bathing twice weekly. He needed help with dressing to put on his shoes and socks. Tenant #10 was independent with toileting. On 12/29/25 at 10:35 a.m. Tenant #10's wife reported the cleanliness of the apartment was better now than it was a few months ago. Her grandchildren did not want to visit Tenant #10 due to the smell of the apartment. She believed the program either needed to pull up the carpet or shampoo it every week or two. When Tenant #10 went to the doctor last week someone reported he smelled of urine. The family hired someone to help him shower each week. In an interview with Tenant #10's daughter on 1/06/26 at 9:35 a.m. she stated she had concerns about the cleanliness of his apartment. She used to go in several times a week to clean it. This was no longer necessary, but it still needed to be cleaned on occasion. For instance, last weekend her mother had to clean the bathroom with several Lysol wipes due to urine being on the floor and toilet. Tenant #10 was interviewed on 1/07/26 at 2:20 p.m. He reported there were times he thought his room needed to be cleaned up. In general, he was not overly bothered by the condition of his room. During an interview with the Executive Director	A 160		

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A 160	Continued From page 26 on 1/06/26 at 3:15 p.m. she reported staff shampooed Tenant #10's carpet earlier in the day but the urine smell remained. She believed they needed to replace the carpet in his apartment.	A 160		
A 245	481-67.5(2)a Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: a. The program shall not prohibit a tenant from self-administering medications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program prevented 1 of 12 tenants reviewed from partially self-administering medication (Tenant #10). Findings follow: Record review on 12/31/25 of progress notes for Tenant #10 revealed an entry on 11/04/25 in which his wife expressed concern because his medication cupboard was locked. The Registered Nurse (RN) reported the program now managed his medication. The wife asked how she would continue to fill his medication planner. The RN educated the wife the program was unable to administer medication if they could not verify what they were giving. Tenant #10's wife asked to schedule a meeting to discuss these changes. It was scheduled for 11/12/25. The next progress note related to medication management was dated 11/25/25. Tenant #10's wife came to the building to discuss medication management. She agreed with the service plan and signed it.	A 245		

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A 245	Continued From page 27 The most recent service plan in Tenant #10's record was dated 10/02/25 and signed by his wife on 10/01/25, but did not match the dates of the progress notes. It identified Tenant #10 required daily assistance to take medication. Staff would order medication for him. Tenant #10's wife was interviewed on 12/29/25 at 10:35 a.m.and reported she used to set up her husband's medication. The prescription medication was put in plastic pouches by the pharmacy. The staff pulled a pouch from the roll and provided this medicine to her husband three times daily. Then all of a sudden the medication cabinet was locked and she was not able to put the pills in the cabinet any longer. The program said either they did all of the medication or she did all of the medication. Her husband was not given a choice about this. During an interview with Tenant #10's daughter on 1/06/26 at 9:35 a.m.she recalled the program started managing her father's medication without notifying him or the family. One day the medication cupboard was locked. Tenant #10 was interviewed on 1/07/26 at 2:20 p.m. he reported he was not told the staff were going to lock up his medication cabinet prior to it being done. Someone came into his apartment and did it without discussing it with him. At the time of the interview, he was agreeable with program staff administering his medication. An interview was conducted with the Executive Director on 1/07/26 at 3:45 p.m., who was hired on 10/06/25 after the service plan was signed, reported she met with Tenant #10's wife to	A 245		

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A 245	Continued From page 28 discuss the tenant's medication being locked. She was not aware tenants had the right to administer their own medication. She confirmed the program failed to discuss this process with Tenant #10 and his team prior to making changes to his medication process. Tenant #10 did not sign the 10/02/25 service plan confirming his agreement with the change.	A 245		
A 270	481-67.5(2)f(1) 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: (1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to follow policy ensuring 1 of 1	A 270		

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former staff reviewed was properly trained prior to administering medication (Staff H). Finding follows:

Record review of Medication Administration Records for the month of September, 2025 with the Executive Director on 1/06/25 at 3:15 p.m. revealed Staff H administered medication to the following tenants on 9/11/25:
1. Tenant #4 was administered Atenolol at 9:11 a.m. and Benzonatate at 9:16 a.m. from Staff H. Both medications were scheduled at 8:00 a.m.

2. Tenant #14 was administered Levothyroxine at 9:47 a.m. by Staff H. This medication was scheduled for 7:00 a.m.

During an interview with Staff H on 1/05/26 at 6:35 p.m.she recalled being delegated to administer medication on her third day of work (which was 9/11/25) by the former Licensed Practical Nurse (LPN), not a Registered Nurse (RN).

Record review on 1/05/26 of training documentation for (former) Staff H revealed she completed her Medication Manager course on 4/24/25. A medication competency evaluation was completed on 9/11/25. Medication policies were reviewed with Staff H on 9/15/25. The RN went over the Medication Management Agreement, which explained the expectations with medication management delegation responsibilities, with Staff H on 9/15/25. The policy noted the employee accepted medication management delegation and the responsibility with medication management. The nurse's signature signified she provided appropriate education regarding the above tasks and

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A 270	Continued From page 30 observed the employee demonstrating competency of the task. The Program ' s Medication Management policy noted medication must be administered by trained and qualified staff. During an interview with the Executive Director and the Health and Wellness Director on 1/07/26 at 3:45 p.m. confirmed staff must be fully trained prior to administering medication. If Staff H was not fully delegated, the program failed to follow their policy on medication administration.	A 270		
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, there was evidence the program failed to provide an adequate number of trained staff potentially affecting 31 of 31 tenants, specifically 9 of 14 current tenants reviewed (Tenant #1, Tenant #4, Tenant #7, Tenant #9, Tenant #12, Tenant #13, Tenant #15, Tenant #16 and Tenant #17) and 1 of 2 discharged tenants reviewed (Tenant C1). Findings include but are not limited to: 1. Record review on 12/29/25 of a Hospice Plan of Care dated 12/04/25 revealed Tenant C1 was an 87-year old woman diagnosed with heart failure, cardiomegaly, pulmonary hypertension, bacteremia, chronic kidney disease stage 3,	A 325		

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dysphagia and colostomy. On 11/09/25, Tenant C1 presented at the Emergency Department (ED) with increased shortness of breath and bilateral lower extremity edema. She was admitted to the hospital for IV Lasix and fluid restriction. While hospitalized, she was seen by wound care for multiple pressure areas. She was found to be bacteremic with enterococcus. Tenant C1 had a chest x-ray performed which showed bilateral pleural effusions consistent with fluid overload. She then aspirated and another chest x-ray was performed showing worsening congestive heart failure. Prior to hospitalization, she was independent with activities of daily living. Due to her significant decline in the hospital and poor response to treatment, hospice was consulted. She was discharged from the hospital back to the program. The Hospice assessment at the program revealed the ostomy was functioning. She had a foley catheter in place. There was a wound to the coccyx and a skin tear to the left arm. Tubigrips were in place to her bilateral lower extremities. Her appetite was poor and she mainly drank protein drinks and ate ice cream. Tenant C1 needed intermittent assistance with feeding. She was on a pureed diet with thickened liquids and took her medication crushed in applesauce. Medications were reconciled with Tenant C1's Primary Care Provider (PCP) and would be managed by the program. She would be on bed rest.

Tenant C1 ' s service plan developed by the program on 12/04/25 noted she was dependent on staff for all mobility. The plan directed taff to turn her every two hours from side to side using wedges and pillows. They could occasionally transfer her to a recliner or chair with an assist of two to three people with a gait belt. She was

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bed-bound. Tenant C1 was totally dependent on staff for medication management. Her pills should be crushed in applesauce. Staff were to provide bed baths twice a week. Tenant C1 required assistance with grooming and oral cares twice per day. She required total assistance with catheter and colostomy care, which staff provided two times daily. Tenant C1 needed regular encouragement to select menu items in compliance with her ordered diet. She may need assistance with feeding appliances as well as feeding at meals or snacks. Staff were to offer her a drink every two hours. She required daily nursing services. Tenant C1 was at risk of skin breakdown. An ulcer was noted on her buttocks. Staff were to monitor for any additional skin issues, open areas, additional discoloring of skin and inform the nurse of any new skin issues.

A skilled nursing note from 12/08/25 identified when the nurse arrived she found Tenant C1's catheter leaked. The ostomy was intact and functioning. She assisted with a bed bath as Tenant C1 was a two person assist. She removed the tubigrips from Tenant C1's legs and indents and redness were noted behind her knees. She called out in pain when the red area caused by the tubigrip was cleaned. The Hospice nurse spoke with staff after the visit and let them know the catheter leaked. She informed them to let her know if the catheter leaked again. They denied any questions.

The Hospice nurse met with Tenant C1 on 12/10/25. The ostomy bag did not have a clamp on it. Tenant C1 said a nurse came in the previous evening and clamped it improperly. She tried to tell the program staff how to do it the right way but the person would not listen. The Hospice

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nurse noticed Tenant C1 was saturated with urine and there was feces on her blanket and ostomy. Staff assisted her with bringing in a new blanket and pad for the bed. The Registered Nurse (RN) then asked how often Hospice would be providing baths to Tenant C1 as the program would not be providing this service when Hospice was doing it. The RN shared Tenant C1 was not receiving medication, other than Warfarin, as it was discontinued when she discharged from the hospital. The Hospice nurse let the RN know the medication was not discontinued and would follow up with the doctor about this. A review of Tenant C1's December, 2025 Medication Administration Record (MAR) revealed Tenant C1 received one dose of Warfarin on 12/05/25. Her other medication did not start until 12/12/25.

The Hospice nurse and bath aide arrived on 12/11/25 to complete a bed bath and bed change. Tenant C1's catheter was leaking again. Her peri area was red with a white discharge noted. The Hospice nurse contacted the PCP for orders to address the discharge. The Hospice nurse again asked staff to let her know if the catheter was leaking.

The Hospice team had a meeting with Tenant C1's PCP on 12/11/25. They discussed concerns the program was unable to meet her needs. They increased home health visits to five per week due to concerns of the catheter leaking and a reddened peri area. The RN contacted the Hospice nurse and informed her she received the medication orders and medicine would be administered when delivered (it was not administered until 12/12/25). Hospice nursing visits were increased to daily to ensure personal cares were met and medications were being

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given. The Hospice nurse met with the Executive Director to discuss her concerns related to medication, the tenant being found saturated in urine from head to toe and the clamp on the colostomy bag missing with stool on the patient and bedding. The Executive Director reported it was unacceptable and would hold a meeting with staff to ensure Tenant C1 was cared for the way she deserved.

The Hospice nurse visited on 12/12/25 with no concerns. On 12/15/25 when the Hospice nurse arrived she learned from the Health and Wellness Director (HWD) Tenant C1 received a complete bath and bed change in the morning as she was saturated in urine. The ostomy bag was emptied prior to her arrival.

When the Hospice Home Health Aide (HHA) arrived on 12/16/25, she found Tenant C1 laying sideways in bed and very confused. Her incontinence pad was saturated with urine and/or discharge from her bottom. Program staff came to assist her with cares. The HHA asked staff how often they were checking on Tenant C1. They informed her they were unable to reposition her every two hours due to low staffing and Tenant C1 requiring a two-person assist. They discussed Tenant C1's level of confusion as this was unusual. Staff reported she was hallucinating through the night but they had not administered any medication to assist with this. Tenant C1's mouth was dry and crusted over. Staff were not feeding Tenant C1, reportedly as they were not certified to do so. She reported pain with repositioning. The HHA provided catheter, incontinence and peri-cares. Staff were unable to provide any clean linen. The HHA placed a clean bath sheet under Tenant C1 until

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clean sheets were provided. The coccyx wound appeared to have a greenish discharge which was new. Staff stated they were unaware of how to care for the wound and asked for information on how to do so.

Two Hospice nurses returned to visit Tenant C1 the afternoon of 12/16/25 and found her clean but gasping for air. Lunch was sitting beside her. She said she ate half a grilled cheese and some ice cream. They pressed the call light and waited 30 minutes for a response. The HWD arrived and they discussed concerns about medication, repositioning and the deterioration of the wound. They asked the HWD why she did not mention Tenant C1 was not receiving medication and was having issues swallowing medication when they met on 12/15/25. The HWD said she saw on 12/16/25 Tenant C1 missed some medication (the December, 2025 MAR did not reflect Tenant C1 missing oral medication). The Hospice nurses reported they were initiating Morphine due to Tenant C1's shortness of breath and pain. A review of December, 2025 did not indicate Morphine was administered to Tenant C1 at all. The HWD returned with two staff who wanted education on how to give these medications. The Hospice team later spoke with Tenant C1's daughter about a transfer to the Hospice House due to concerns about the program. Tenant C1 and her daughter decided she would move to the Hospice House on 12/17/25.

A Hospice nurse was interviewed on 12/29/25 at 12:22 p.m. She reported Tenant C1 was admitted to hospice on 12/4/25. A big concern of hers was the ability of staff to safely reposition and bathe Tenant C1 while she was in bed. This could be scary as she was a larger lady and the

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task required a two-person assist. It could be dangerous if only one person did it and she was afraid Tenant C1 would fall out of bed. The Hospice nurse provided a list of services which the program did not provide adequately:
- the discharge medication list was not correct
- medication was not administered for several days
- Tenant C1 was not checked frequently. She would expect someone who was bed-bound to be checked every 2-3 hours.
- The ostomy bag was not closed.
- Staff were alerted if there were problems with the ostomy or catheter to call Hospice but this was not done.
- Medications were not administered from the comfort kit.
- Staff reported they were not certified to feed Tenant C1 so she did not receive nourishment.
- They put fungal cream intended for her wound on the peri area.
- It did not appear wound care was completed as ordered.

Tenant C1's daughter was interviewed on 12/29/25 at 6:03 p.m.. She reported the RN evaluated her mother prior to her discharge from the hospital and was aware she was bed-bound and required two people for repositioning. The Executive Director assured the daughter they had more staff and would be able to meet her needs. The daughter called the RN when she learned her mother was not receiving her medication and was told there was confusion with the pharmacy and no one knew the program was to administer the medication. She recalled going to her mother's apartment and finding cups staff left everywhere. Staff would leave grilled cheese sandwiches and soup at her bedside.

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A 325	Continued From page 37 The daughter did not understand why this was done if her mother was choking on pills. They provided her mother with 20 ounce tumblers she could not handle and short straws which fell into the cup. The daughter bought sippy cups which the program lost. Things were bad on 12/16/25. When she talked with the new HWD she did not seem to know what medication her mother took or if her mother was swallowing her pills. The Executive Director reportedly stated she did not know there were problems related to her mother's care. During an interview with Staff G on 12/29/25 at 1:10 p.m. she reported it took two staff to reposition or turn Tenant C1. They had to turn her in bed every two hours and she was unable to do this by herself. There were times she was worried Tenant C1 would fall off the side of her bed as it was small and the tenant was a larger lady. They put a wedge under Tenant C1, but were unable to put her on her side. They tried to do everything they could, but when there was only one staff and during the nighttime shift Tenant C1 could not be repositioned with only one employee. She did not recall seeing Tenant C1's catheter bag leaking but did know her coccyx wound was leaking a green substance. Staff G reported staff were not allowed to feed tenants at the program due to concerns of aspiration. She knew Tenant C1 had a hard time swallowing and would even gag if she tried to feed herself. For this reason, Staff G would bring food in to Tenant C1 and leave it at her bedside. Staff E was interviewed on 1/06/26 at 10:15 a.m. and recalled the first time she tried to give Tenant C1 a pill she refused it. Staff E then offered to give the pill to her in applesauce but the tenant	A 325		

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said no. The pill was not crushed. She then shared with Hospice staff Tenant C1 choked on her medication.

In an interview with Staff D on 12/31/25 at 10:55 a.m. she stated it required two people to safely reposition Tenant C1 in bed as she was a big lady. When she worked at night, the employee covering the secured memory care unit was not able to assist with this task so she had to do it by herself.

The program failed to routinely provide an adequate number of staff to safely reposition Tenant C1. The Hospice team was not notified when Tenant C1's catheter and ostomy were leaking. The RN discontinued her medication for an unknown reason. Staff were not properly trained in following Tenant C1's diet, when to administer PRN medication to a tenant on Hospice or following wound orders.

2.Record review on 12/31/25 of a History and Physical revealed Tenant #4 carried diagnoses of Diabetes mellitus Type 2, obesity, chronic kidney disease stage III, central cord syndrome, cervical canal stenosis, neurogenic claudication, wheelchair dependent; hypertension and history of feet ulcers and wounds. The RN documented in a progress note on 11/19/25 Tenant #4 went for a podiatry appointment on 11/18/25 and received new orders for a dressing to the right heel daily, protect with gauze and tape or a band aid. Keep the area clean and dry. She faxed the order to the pharmacy and added this to the Medication Administration Record (MAR).

The Health and Wellness Director assessed Tenant #4's lower left extremity on 12/22/25 and

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noted he had redness and multiple open areas with serous drainage. He reported severe pain to the area if touched. She also assessed an open area to his inner left fifth toe.

A History and Physical dated 12/23/25 indicated Tenant #4 presented at the hospital due to a black discoloration at the tip of his left fifth toe without pain in his foot. He also had black discoloration to his right heel. An MRI of the left foot showed signs of osteomyelitis of the left fifth toe (a bone infection). He was also diagnosed with cellulitis. During the course of his hospitalization Tenant #4 chose to have an amputation of his left small toe rather than go through a prolonged course of IV antibiotics. This surgery was conducted on 12/26/25. Tenant #4 discharged from the hospital and returned to the program on 1/6/26.

During an interview with Staff C on 12/30/25 at 1:45 p.m. she reported Tenant #4's leg began hurting the week before Thanksgiving after he slid off a chair. The pain increased after that time. Tenant #4 did not want to get his weight taken daily. Tenant #4 was out of his Hydrocodone and this was a medication the nurse had to refill. She reported this to the HWD and Executive Director who directed her to administer Acetaminophen. She recalled reporting to the RN on her last day in the building Tenant #4 was in so much pain he couldn't even stand.

Staff A was interviewed on 12/31/25 at 10:15 a.m. She applied lotion to Tenant #4's knees and put a bandage on his heel. She did not notice issues with his heel. She did notice throughout the month of December Tenant #4 had a skin tear on his leg which seemed to be getting worse. His

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legs also seemed to be getting bigger and redder. She was not sure if this was related to him retaining fluid or putting on weight. Staff A said his condition did not concern her enough; she thought it needed to be reported to the nurse.

In interviews with Staff E on 1/06/26 and 1/13/26 she recalled seeing Tenant #4's legs when they were red and reporting it to the RN. Staff E applied lotion to Tenant #4's legs and also put bandages on his heel, both daily. His heel looked calloused, but not black. When she put the bandage on Tenant #4's heel he requested she not remove his sock as it was hard to put on and hurt. When she noticed the sores on Tenant #4's were leaking (on 12/22/25), she notified the HWD who immediately assessed his condition. Staff E remembered Tenant #4 asked her for his pain medication, Hydrocodone, in December, but it was not available as they ran out of the pills. She asked the nurse to request a refill but this did not occur.

When interviewed on 12/31/25 at 10:55 a.m. Staff D recalled noticing Tenant #4's legs were getting bad on 12/21/25. They were oozing a bit and swelling. She did not report this information to the program nurse the evening of 12/21/25. The morning of 12/22/25, she informed her co-worker of his condition at shift change.

During an interview with the HWD on 1/07/26 she reported when staff were applying a bandage to a tenant's heel they should remove his sock, assess for changes and report if there was a change or the tenant voiced a change. Staff members should have notified the RN or HWD when Tenant #4's leg was red, painful and had

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A 325	Continued From page 41 sores. The program failed to ensure the RN was coordinating with Tenant #4's providers to get his current wound orders. The RN did not follow up when she received reports from staff about concerns regarding Tenant #4's health or refilling his medication. The RN did not ensure staff were properly trained to provide wound care to Tenant #4, to identify changes to his skin and to report changes immediately. 3) Observations on 12/29/25 from 11:15 a.m. to 11:55 a.m. revealed the following medication administration: a. Tenant #9 received the following medication at 11:15 a.m.: Losartan 100 mg. (scheduled for 8:00 a.m.), Rosuvastatin 10 mg. (scheduled for 8:00 a.m.), Omeprazole 20 mg. (scheduled for 6:00 a.m.) and Levothyroxyn (scheduled for 6:00 a.m.). b. Tenant #12 received the following medication at 11:25 a.m.: Buspirone 5 mg. (scheduled at 8:00 AM), Miralax 510 grams (scheduled midday from 10:00 a.m. - 2:00 p.m.), Deep Sea Nasal Spray (scheduled for 8:00 a.m.) and Biofreeze (scheduled for 8:00 a.m.). c. Tenant #1 received the following medication from 11:35 a.m. to 11:55 a.m.: Chlorhexidine (scheduled for 8:00 a.m.), Docusate Sodium 100 mg. (scheduled for 8:00 a.m.), Famotidine 20 mg. (scheduled for 8:00 a.m.), Losartan 50 mg. (scheduled for 8:00 a.m.), Lorazepam 0.5 mg. (ordered at 8:00 a.m.), nutritional supplement (take 1 in the a.m.), Preservision Areds 2 (ordered at 8:00 a.m.), Risperdal 0.25 mg (ordered at 8:00 a.m.), Senna 8.6 mg. (scheduled for 8:00 a.m.), Sertraline 100 mg. (scheduled for	A 325		

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A 325	Continued From page 42 8:00 a.m.), Trazodone 50 mg. (scheduled for 8:00 a.m.), Vitamin D3 2000 iu (scheduled for 8:00 a.m.), Vaseline (scheduled for 8:00 a.m.). A further medication administration observation was conducted on 12/31/25 at 10:37 AM with the HWD. She administered the following medication to Tenant #9: Losartan 100 mg. (scheduled for 8:00 a.m.), Rosuvastatin 10 mg. (scheduled for 8:00 a.m.), Omeprazole 20 mg. (scheduled for 6:00 a.m.) and Levothyroxyn (scheduled for 6:00 a.m.). Record review of September, 2025 MARs revealed the following medications were administered on 9/11/25: a. Tenant #4 received Atenolol (scheduled for 8:00 a.m.) at 9:11 AM and Benzonatate (scheduled for 8:00 a.m.) at 9:16 a.m. from (former) Staff H. b. Tenant #14 received Levothyroxyn (scheduled for 7:00 a.m.) at 9:47 a.m. and Potassium (scheduled for 8:00) at 9:47 a.m. from Staff H. During an interview with Staff C on 12/29/25 at 6:47 p.m. she reported administering medication to tenants might take most of the morning until almost noon. Staff C felt good if she completed medication by 10:00 a.m., even though she knew most of the pills should be administered by 9:00 a.m.. When interviewed on 12/30/25 at 11:06 a.m. Staff A reported she heard tenants report they don't get their medication until late morning. She saw the medication managers passing pills until the late morning. When interviewed on 12/29/25 at 1:10 p.m. Staff	A 325		

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A 325	Continued From page 43 G stated it was typical for it to take most of the morning for all of the tenants' medication to get administered. Tenant #16 interviewed on 12/30/25 at 9:15 a.m. expressed what worried her the most was when staff didn't show up on a routine basis with her medication. She felt they should show up within an hour of the prescribed time with her medication. She took medication for her heart, blood pressure and anxiety. The other day she asked staff at night if she got her afternoon anxiety pill and they told her she did not. Her anxiety worsened when she didn't get her anxiety medication. She only used her pendant in an emergency or when it was past 10:00 a.m. and she hadn't received her medication. In September, 2025 they would bring her medication at all hours of the day. Tenant #16 believed the issue was the program did not have enough staff. If there were more staff they would be able to administer medication on time. Her other concern was related to not having her apartment cleaned for two to three weeks at a time. During an interview with Tenant #17 on 12/30/25 at 10:15 a.m. expressed there were a number of concerns about the running of the program in September, 2025 although she believed things had really improved. In September, she received her medication at all hours, including around midnight and 4:00 a.m. She recalled one day when she didn't get any medication until the afternoon. The employee who was supposed to show up in the morning did not come to work. No one was there to give medication until the afternoon.	A 325		

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A 325	Continued From page 44 The HWD reported during the medication pass on 12/31/25 at 10:37 a.m. the acceptable time to administer medication was one hour before or one hour after the scheduled or time ordered by the PCP. 4. Record review on 1/07/26 revealed December, 2025 and January, 2026 Device Activity Reports which provided information on the length of time it took staff to respond after a tenant pushed their emergency response pendants for assistance. a. Tenant #7 had a history of transient ischemic attack (TIA) and cerebral infarction based on her face sheet. The Device Activity Reports noted when Tenant #7 pressed her pendant for assistance in December, it took staff more than 15 minutes to respond on 41 occasions. The longest response time was 45 minutes. During the period of 1/1/26 - 1/5/26, there were 5 occasions it took staff more than 15 minutes to provide Tenant #7 with assistance. The longest period of time to respond was fifteen minutes. During an interview with Tenant #7 on 1/05/26 at 11:20 a.m. she reported she used to be more independent. However, since she had a stroke, she couldn't get up and go to the bathroom on her own as she was unable to move her foot and had to wait for staff to walk her to the toilet. In addition, she had to use the bathroom more since having the stroke. An observation of Tenant #7 revealed she used a walker and required standby assistance from staff when ambulating due to an unsteady gait. b. A review of the Device Activity Report indicated Tenant #13 pushed her pendant for assistance and had to wait over 15 minutes for assistance	A 325		

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A 325	Continued From page 45 on 27 occasions in December. The longest wait time was 50 minutes. She pushed her pendant six times in January, with the longest wait being 41 minutes. Tenant #13 reported she was 102 years old. She would push her pendant for assistance when she fell or needed assistance getting to the bathroom. There were times she waited for staff to help her but they did their best. She did wish staff would be better about cleaning her apartment as there were times it could be three to four weeks when there was no housekeeping. c. A review of incident reports revealed the following: - On 12/03/25 at 8:30 a.m. staff documented Tenant #4 reported a fall from his recliner after his legs became weak. The Device Activity Report indicated he pushed his pendant for help at 8:16 a.m. It took staff 23 minutes and 19 seconds to respond. - On 12/23/25 at 10:00 a.m. staff noted Tenant #15 attempted to pick up a paper from her floor and lost her balance. Information from the Device Activity Report revealed she pressed her pendant for help at 9:42 a.m. and it took 16 minutes and 38 seconds for a response. -On 12/29/25 at 1:10 p.m. Staff G explained when she gave a tenant a shower today she saw three tenant's pendants alarm. She was unable to leave the tenant showering alone. She didn't know who was able to respond to help the tenants. She's filled out a form for the Executive Director about why she was unable to respond in a timely manner to the pendants. She wasn't always able to provide showers to all tenants as scheduled. Most nights she went home	A 325		

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A 325	Continued From page 46 completely exhausted. During an interview with Staff C on 12/29/25 at 6:47 p.m. she indicated there were times when in the evening one employee was responsible for administering medication, doing showers and responding to pendants. There were times she called for help on the radio but no one was available to provide assistance. Pendants might be going off for 35 to 40 minutes before she was able to respond, including tenants who were on Hospice. There were times when they were not able to reposition tenants every two hours as required as there was not a second person available to assist with this. Staff A was interviewed on 12/30/25 at 11:06 a.m. She reported the work load was initially manageable, but the tenants in the building now required more care. She was able to provide the individuals with the basic needs like getting up and taking them to the bathroom during her shift. However Staff A was not able to do things like complete laundry or give tenants showers as scheduled. When interviewed on 12/30/25 at 12:14 p.m. Staff B indicated there were times she needed an extra pair of hands to help. She noticed the staff in the secured memory care unit might have issues with tenants who were displaying behaviors, trying to elope or need repositioned and there wasn't anyone who was able to provide assistance. Staff B noticed there were times it could take 30 minutes before staff was able to provide assistance to a tenant at times. On 12/29/25 at 9:19 a.m. the Executive Director reported the goal was for staff to respond to	A 325		

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A 325	Continued From page 47 pendants within 10 minutes or less. Any time over 10 minutes was concerning to her. The HWD and Executive Director stated on 1/07/26 at 3:45 PM they acknowledged tenant needs could not be met with only one staff in each part of the building. Staffing levels were their number one concern at this time.	A 325		
A 150	481-69.23(1)a 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: a. Is bed-bound This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program retained 1 of 12 current tenants reviewed (Tenant #5) and 1 of 2 discharged tenants reviewed (Tenant C1) who were bed-bound. Findings follow: 1. Record review on 12/31/25 revealed a notebook for Tenant #5 with handwritten entries from staff, family and hospice workers dated 10/24/25 to 12/23/25. The entries detailed cares provided to Tenant #5 during this time. Entries included the following: - 10/28/25: Sitting up in the main area and got back to bed when she started getting tired. - 11/18/25: Tried sitting up so we transferred her to the living room. - 12/1/25: Hospice came and gave her a bed bath at 12:15 p.m.	A 150		

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- 12/19/25: She was repositioned to her right side at 1:30 p.m. Rolled to her left side at 7:00 p.m. Rolled to her back at 10:00 p.m.
- 12/21/25: Changed and repositioned with a two person assist. She mostly likes to be flat on her back.

The last entry made of Tenant #5 being out of bed occurred on 11/18/25.

Tenant #5 ' s service plan, dated 12/19/25, noted she was bed-bound requiring frequent position changes.

During an interview with Staff A on 12/30/25 at 11:06 a.m. she reported the last time she saw Tenant #5 out of bed was in October, 2025.

Staff B was interviewed on 12/30/25 at 12:14 p.m.stated she last saw Tenant #5 out of bed about a month ago.

In an interview with Staff D on 12/31/25 at 10:55 a.m. she could not recall seeing Tenant #5 out of bed for the past month.

2. A progress note for Tenant C1 dated 12/04/25 noted she returned to the community on that date from the hospital under hospice care.

A service plan was developed for Tenant C1 on 12/04/25 which noted she was totally dependent on staff for all mobility and ambulation needs and required hands-on assistance on a routine basis. Staff were to turn her every two hours from side to side. She was bed-bound requiring frequent position changes.

A Hospice Plan of Care, dated 12/04/25, identified Tenant C1 was being admitted for

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A 150	Continued From page 49 services on that date. Her activity level was noted as "complete bed rest". Staff A reported on 12/30/25 at 11:06 a.m. Tenant C1 did not get out of bed from the time she returned from the hospital (12/04/25) until she discharged from the program. Staff B indicated Tenant C1 did not get out of bed from the time she began hospice services (on 12/04/25). Staff D reported Tenant C1 did not leave her bed after returning from the hospital. During an interview with the Executive Director and the Health and Wellness Director on 1/07/26 at 3:45 p.m. they confirmed the program failed to discharge Tenant #5 and Tenant C1 when they became bed-bound.	A 150		
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 complete a nursing note when 1 of 12 current tenants reviewed went to the	A 290		

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(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 50 emergency room (Tenant #9). Finding follows: Record review on 1/20/26 of notes from the emergency department revealed on 11/26/25 Tenant #9 moved to the program one to two days earlier. She was very aggressive to staff and called her daughter over 100 times. Staff sent her to the emergency department as they could not manage her anymore. A review of progress notes provided on 12/31/25 revealed no entry detailing Tenant #9's emergency room visit on 11/26/25. On 1/20/26 at 12:19 p.m. the Vice President of Clinical Services reported the event had since been entered in the progress notes.	A 290		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to update the service plan for 2 of 12 current tenants reviewed (Tenant #4 and Tenant #9) and 1 of 2 discharged tenants	A 350		

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A 350	Continued From page 51	A 350		

reviewed when their needs changed (Tenant C2). Findings follow:

1. Record review on 12/31/25 of Tenant #4 ' s file revealed the following:

a.Record review on 12/31/25 of progress notes for Tenant #4 revealed an entry from 9/02/25 in which his wife reported to the Registered Nurse (RN) she was taking him to the Emergency Department at the advice of his Primary Care Provider (PCP) due to pain in his chest. He returned on 9/03/25 with follow up appointments for wound care, his PCP, an echocardiogram, cardiology and the Surgical Specialists. The RN called the wife to see if she would make the appointments or if the RN should do it but received no return call. There was no documentation the RN followed up with the wife about the appointments, specifically wound care.

The RN noted Tenant #4 complained of pain to his left ankle on 10/28/25. She assessed his left leg and noted edema and pinkness in scattered areas on his shin as well as a small area which was open, pink and raised on the front of the shin. When touching around this area he grimaced and said it was very painful. He requested to go to the Emergency Department for an evaluation. The facility driver took him to the hospital. There were no new orders from the visit.

The RN documented on 11/19/25 Tenant #4 went for a podiatry appointment on 11/18/25 and received new orders for a dressing to the right heel daily, protect with gauze and tape or a band aid. Keep the area clean and dry. She faxed the order to the pharmacy and added this to the

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A 350	Continued From page 52 Medication Administration Record (MAR). The Health and Wellness Director assessed Tenant #4's lower left extremity on 12/22/25 and noted redness and multiple open areas with serous drainage. He reported severe pain to the area if touched. She also assessed an open area to his inner left fifth toe. Tenant #4 went to the hospital where he was started on IV (intravenous) antibiotics for a bilateral lower extremity infection. He had his fifth left toe amputated due to osteomyelitis (an infection in the bone). b. A review of notes from a wound care clinic identified Tenant #4 was seen for treatment of bilateral heel ulcerations on 9/09/25. Current dressings were to include application of gentamicin cream, then dressings with gauze and secured with tape. He denied any pain in his feet due to a history of diabetic peripheral neuropathy. He had heel protector boots with him at previous visits, however they were not in place. He indicated they had not been put on his feet for quite some time. Treatment continued approximately every two weeks through 10/14/25 at which time the ulcers were healed. However the provider noted the overlying skin was very thin and fragile. She encouraged him to keep the area well protected with a dry dressing of gauze and tape or a dry band-aid which should be changed daily for at least the next seven days. It should be kept clean with soap and water. Tenant #4 returned to the wound clinic on 11/18/25 (not the podiatry clinic) at the recommendation of his PCP. The ulcers were still	A 350		

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A 350	Continued From page 53 healed but the skin remained fragile. The provider recommended he continue with the treatment orders from 10/14/25 for at least another seven days. He went back to the wound clinic on 12/12/25 for an evaluation of multiple nonhealing wounds to his lower extremity. He said he developed the wounds several weeks ago. He had 2+ pitting edema to his bilateral lower extremities. The PERI ulcer tissue was dry and flaky. The provider recommended using Prisma covered with gauze and secured with tape and two layers of Tubigrip. The importance of compression and elevation were reviewed. There was also a non-pressure injury to his left medial fifth toe (there is no evidence the program carried out these orders). c. Tenant #4 ' s service plan dated 6/27/25 noted his skin conditions of eczema and dry skin. There was no mention of edema or ulcers to his lower extremities. The program failed to update Tenant #4's service plan when he experienced significant changes related to the condition of his skin. During an interview with the Executive Director and Health and the Wellness Director on 12/31/25 at 11:50 a.m. they confirmed the program failed to update Tenant #4's service plan when he had a change of condition related to his lower extremities. 2. Record review of Tenant #9 ' s file revealed the following: a. A progress note for Tenant #9 indicated she moved to the program on 11/24/25. She resided in the secured memory care unit. That evening	A 350		

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A 350	Continued From page 54 the RN was called to the unit as Tenant #9 yelled "Let me out of here!". She attempted to leave the building for several hours. The RN contacted Tenant #9's PCP and received a verbal order for an intramuscular (IM) injection of Lorazepam. The injection was administered and she began to calm down. b. A hospital record dated 11/26/25 revealed Tenant #9 presented at the hospital via ambulance due to concerns for agitation and aggression at the program. Her three children were at bedside. They reported since admission to the program, Tenant #9 called them over 100 times being verbally aggressive, screaming and threatening. She kept asking to return home and was not sleeping. The consulting doctor prescribed medication which would be given as needed for the safety of Tenant #9 and the people around her. They agreed standing medication would do more harm than good. c. An incident reported dated 12/04/25 documented Tenant #9 fell on the floor when getting into bed. She did not require medical treatment. An incident report from 12/05/25 noted the afternoon of 12/04/25, Tenant #9 was more lethargic and sleepy. It continued through the morning of 12/05/25. PRN Haloperidol as well as Lorazepam were administered. No other abnormal behavior was noted. Tenant #9 stated she did not feel right. She was transported to the hospital for an evaluation. d. Review of a Final Report from Tenant #9's hospitalization (from 12/5/25 - 12/9/25) revealed she presented with lethargy and a fall. The patient was aggressive with a behavior change. It seemed as if Tenant #9 was being	A 350		

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A 350	Continued From page 55 overmedicated at the nursing facility. e. An initial service plan developed for Tenant #9 on 11/17/25 noted she had no anxiety or awareness issues. She had occasional behavior issues which may require special tolerance from staff two times per day. Tenant #9 was noted to have occasional mood and depression issues. She had moderate wandering issues. Staff I interviewed on 12/31/25 at 1:40 p.m. reported Tenant #9 liked to push on the exit door to go outside and feel the weather. She recalled Tenant #9 being lethargic and falling for about three days before she went to the hospital on 12/05/25. During an interview with Staff B on 12/30/25 at 12:14 p.m. she reported Tenant #9 used to frequently exit-seek but calmed down a great deal since she first moved to the program. The program failed to update Tenant #9's service plan to address her aggression, anxiety, exit-seeking, falling and hospitalization. 3. Record review of Tenant C2 ' s file revealed the following: a. Tenant C2 ' s service plan, dated 11/23/25 identified he experienced moderate cognitive impairment. He received outside services from Hospice and an aide from the Veteran's Administration (VA). Staff would prepare his meals but he was able to feed himself, chew and swallow foods. He needed reminders and cueing to maintain an adequate intake. b.Tenant C2 ' s notes from a respite provider	A 350		

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A 350	Continued From page 56 revealed : -11/14/25: did not need help eating today -11/17/25: did not need assistance with eating today -11/21/25: assisted with feeding him breakfast this morning, he did not eat a lot. -11/2425-11/26/25: assisted with feeding breakfast this morning. -11/28/25 - assisted with feeding breakfast this morning. -12/2/25 - assisted with feeding. He only ate a sausage this morning. Got him to drink a boost. During an interview with Staff C on 1/07/26 at 1:05 p.m. she reported the wife of Tenant C2 would have to feed him as he forgot how to feed himself. Staff would help to feed him if they were able to do so. Tenant C2's wife was interviewed on 1/07/26 at 3:20 p.m. She explained her husband was often unable to feed himself at the end of his life. When she was able, she would help him with this. During an interview on 1/07/26 at 3:45 p.m. the Executive Director and the Health and Wellness Director confirmed the program failed to update service plans as needed with a change of condition.	A 350		
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 370		

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A 370	Continued From page 57 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 ensure service plans were signed by 1 of 12 tenants reviewed (Tenant #8) and 1 of 2 discharged tenants reviewed (Tenant C1) and not their family members. Findings follow: 1. Record review on 1/06/26 of a service plan for Tenant #8 dated 10/02/25 revealed it was signed by his wife on 10/01/25 but not the tenant. The service plan indicated he had mild cognitive impairment. Tenant #8's wife was not his power of attorney. 2. Review of a service plan for Tenant C1 dated 12/04/25 revealed it was signed by her daughter, but not the tenant. The service plan noted she had mild cognitive impairment. Tenant C1's daughter was not her power of attorney. During an interview on 1/07/26 at 3:45 p.m. the Executive Director and the Health and Wellness Director confirmed the program failed to ensure tenants were signing their own service plans.	A 370		
A 420	481-69.27(1)a Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program	A 420		

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A 420	Continued From page 58 shall provide for a registered nurse: a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to conduct a nurse review when 3 of 12 current tenants experienced a change in their mental or physical health (Tenant #4, Tenant #9 and Tenant #11). Findings follow: 1. Record review on 12/31/25 of Tenant #4 ' s filed revealed the following: a. Tenant #4 ' s progress notes and incident reports revealed an entry from 9/02/25 indicated his wife reported to the Registered Nurse (RN) she was taking him to the Emergency Department at the advice of his Primary Care Provider (PCP) due to pain in his chest. He returned on 9/03/25 with follow up appointments for wound care, his PCP, an echocardiogram, cardiology and the Surgical Specialists. The RN called the wife to see if she would make the appointments or if the RN should do it but received no return call. There was no documentation the RN followed up with the wife about the appointments, specifically for wound care.	A 420		

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A 420	Continued From page 59 The RN noted Tenant #4 complained of pain to his left ankle on 10/28/25. She assessed his left leg and noted edema, pinkness in scattered areas on his shin as well as a small area which was open, pink and raised on the front of the shin. When touching around this area he grimaced and said it was very painful. He requested to go to the Emergency Department for an evaluation. The facility driver took him to the hospital. There were no new orders from the visit. The RN documented on 11/19/25 Tenant #4 went for a podiatry appointment on 11/18/25 and received new orders for a dressing to the right heel daily, protect with gauze and tape or a band aid. Keep the area clean and dry. She faxed the order to the pharmacy and added this to the Medication Administration Record (MAR). Incident reports revealed Tenant #4 had an unwitnessed fall on 11/17/25 resulting in a left elbow skin tear. He did not hit his head. On 11/25/25, Tenant #4 transferred from his wheelchair to the recliner and felt like the room was spinning. He fell down. Tenant #4 requested to go to the Emergency Department. On 12/02/25, Tenant #4's legs became weak when he attempted to transfer from his recliner to the wheelchair. A nurse review was not conducted following these episodes of weakness. The Health and Wellness Director assessed Tenant #4's lower left extremity on 12/22/25 and noted redness and multiple open areas with serous drainage. He reported severe pain to the area if touched. She also assessed an open area to his inner left fifth toe. Tenant #4 went to the hospital where he was started on IV	A 420		

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A 420	Continued From page 60 (intravenous) antibiotics for a bilateral lower extremity infection. He had his fifth left toe amputated due to osteomyelitis (an infection in the bone). b. Tenant #4 ' s notes from a wound care clinic identified he was seen for treatment of bilateral heel ulcerations on 9/09/25. The wound clinic prescribed treatment of gentamicin cream applied to the right heel daily, cover with gauze and secure with tape. He denied any pain in his feet which the provider believed was due to a history of diabetic peripheral neuropathy. He had heel protector boots with him at previous visits, however they were not in place. He indicated the boots were not put on his feet for quite some time. A review of Tenant #4's September MAR indicated staff applied a thin layer of gentamicin cream daily. An area for application was not specified, although the MAR noted the cream was for a foot ulcer. There was no mention of covering with gauze or tape on the MAR. Program staff continued to apply the gentamicin cream through 12/20/25. Treatment at the wound clinic continued approximately every two weeks through 10/14/25 at which time the ulcers were healed. However the provider noted the overlying skin was very thin and fragile. She encouraged him to keep the area well protected with a dry dressing of gauze and tape or a dry band-aid which should be changed daily for at least the next seven days. It should be kept clean with soap and water. The order for gentamicin cream was not discontinued at this time on the program MAR. An order for a dry dressing of gauze and tape or a dry band-aid was not added to the MAR.	A 420		

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A 420	Continued From page 61 Tenant #4 returned to the wound clinic on 11/18/25 (not the podiatry clinic) at the recommendation of his PCP per the clinic note. The ulcers were still healed but the skin remained fragile. The provider recommended he continue with the treatment orders from 10/14/25 for at least another seven days. He could apply a lotion of his choice. These orders were added to the MAR on 11/22/25 and continued through 12/22/25. Tenant #4 went back to the wound clinic on 12/12/25 for an evaluation of multiple nonhealing wounds to his lower extremity. He indicated he developed the wounds several weeks ago. He had 2+ pitting edema to his bilateral lower extremities. The skin surrounding the ulcer was dry and flaky. The provider recommended using Prisma (a wound dressing) covered with gauze and secured with tape and two layers of Tubigrip. The importance of compression and elevation were reviewed. There was also a non-pressure injury to his left medial fifth toe. These orders were not added to the MAR. On 1/5/26 at 10:15 AM the Vice President of Clinical Services reported Tenant #4's wife usually took him out for appointments. When they returned, the RN would ask for information about the appointment and the wife would say the papers were in the car and she would bring them in later. The RN frequently did not get information about the appointment. The RN only knew what information she was given by the tenant and his wife. During an interview on 12/31/25 at 11:50 a.m.with the Executive Director and the Health and Wellness Director confirmed the program failed	A 420		

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A 420	Continued From page 62	A 420		

to conduct a nurse review to ensure Tenant #4's medication and orders were correct following a change in his health.

2) Record review on 1/06/26 Tenant #11 ' s service plan, dated 12/16/25 indicated she had occasional behavior issues. Tenant #11 may have current or a history of occasionally disruptive, aggressive or socially inappropriate behavior. She had bilateral dryness and pain at the ankle area. She was not known to have judgement issues or resist care.

A review of progress notes revealed on 12/17/25 the Health and Wellness Director performed wound care to Tenant #11's coccyx. The wound bed was dark pink and no swelling or drainage was noted. On 12/26/25 new orders were received for physical therapy. Tenant #11 reported she hated it at the program on 12/26/25. The Health and Wellness Director provided validation. The ARNP met with Tenant #11 on 12/29/25. She discontinued the dressing and cream to Tenant #11's coccyx.

During an interview on 12/30/25 at 11:06 a.m. Staff A stated staff did not want to enter Tenant #11's apartment by themselves as she made comments about staff stealing from her. The tenant also said she wanted to kill herself. Staff A could spend one to one and half hours a day taking care of Tenant #11 each day as well as her co-workers. It generally took 45 minutes four to five times a day for staff to take her to the restroom.

In an interview on 12/29/25 at 6:47 p.m. Staff C indicated she spent one hour and 40 minutes with Tenant #11 due to the extent of cares she

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(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 420	Continued From page 63 required. When interviewed on 1/06/26 at 10:15 a.m. Staff E reported she would spend three to four hours with Tenant #11 during a shift. She was often yelled at by the tenant. The tenant swung her arm at Staff E in an attempt to hit her and called her names. She reported this to the Executive Director and the Health and Wellness Director. It often took two staff to transfer Tenant #11. During an interview on 12/29/25 at 1:10 p.m. Staff Grecalled it would take an hour to provide morning cares to Tenant #11 due to her personality and physical issues. The program nurse failed to complete a nurse review when Tenant #11 developed a wound on her coccyx, received an order for physical therapy and displayed changes in her mental health requiring the need for medication and interventions. 3. Record review on 1/05/26 revealed Tenant #9 ' s progress notes indicated she moved to the program on 11/24/25. She resided in the secured memory care unit. That evening the RN was called to the unit as Tenant #9 yelled "Let me out of here!". She attempted to leave the building for several hours. The RN contacted Tenant #9's PCP and received a verbal order for an intramuscular (IM) injection of Lorazepam. The injection was administered and she began to calm down. A hospital record dated 11/26/25 revealed Tenant #9 presented at the hospital via ambulance due to concerns for agitation and aggression at the program. Her three children were at bedside.	A 420		

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 01/20/2026

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A 420	Continued From page 64 They reported since admission to the program, Tenant #9 called them over 100 times, being verbally aggressive, screaming and threatening. She kept asking to return home and was not sleeping. The consulting doctor prescribed medication which would be given as needed for the safety of Tenant #9 and the people around her. They agreed standing medication would do more harm than good. An incident reported dated 12/04/25 documented Tenant #9 fell on the floor when getting into bed. She did not require medical treatment. An incident report from 12/05/25 noted the afternoon of 12/04/25, Tenant #9 was more lethargic and sleepy. It continued through the morning of 12/05/25. PRN Haloperidol as well as Lorazepam were administered. No other abnormal behavior was noted. Tenant #9 stated she did not feel right. She was transported to the hospital for an evaluation. Review of a Final Report from Tenant #9's hospitalization (from 12/5/25 - 12/9/25) revealed she presented with lethargy and a fall. The patient was aggressive with a behavior change. It seemed as if Tenant #9 was being overmedicated at the nursing facility. The program failed to conduct a nurse review when Tenant #9 displayed a change in her condition related to medications changes to address aggression, anxiety and exit-seeking; falling and following an emergency room visit/hospitalization.	A 420		