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
	S0360	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN ALP/I	1275 W FOREVERGREEN ROAD NORTH LIBERTY, IA 52317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive disorder: 3 Tenants with cognitive disorder: 17 Total Census of Assisted Living Program for People with Dementia: 20 The following regulatory insufficiencies were cited during the investigation of Incident #130983-I and the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	A 000		
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 established policy and procedure related to the completion of incident reports. This pertained to 2 of 4 tenants reviewed (Tenant #1 and Tenant #3). Findings follow: 1. Record review on 4/14/26 and 4/15/26 of Tenant #1's file revealed Tenant #1's Observations (nurse's notes), dated 11/19/25 indicated a staff to nurse communication from 11/11/25, staff heard the door alarm sound. Staff responded and observed Tenant #1 attempting to elope from the memory care unit. It noted staff was able to redirect Tenant #1 back into the unit.	A 150		

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

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A 150	Continued From page 1 Continued record review revealed an incident report failed to be completed related to the incident on 11/11/25 with Tenant #1. 2. Record review on 4/15/26 of Tenant #3's file revealed a Staff to Nurse Communication Form dated 1/2/26, indicated staff reported to another staff Tenant #2 said she fell two days ago and did not report it. The form indicated there were no visible signs of injuries. Continued record review revealed an incident report failed to be completed related to the incident on 1/2/26 with Tenant #3. Record review on 4/13/26 of the Program's policy, incident reporting, dated 9/6/17, indicated all accidents or unusual occurrences that affected a tenant should be reported as incidents. An Incident Report Form would be completed for all falls, injuries, medication errors, accidents, anything unusual and allegations of abuse. When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness confirmed the above finding.	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 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide care, services and treatment that were adequate and appropriate related to elopement and safety. This pertained to 1 of 1 tenant reviewed that eloped (Tenant #1). Finding follows: Record review on 4/14/26 of Tenant #1's file revealed an incident report indicated on 12/10/25 Tenant #1 exited out of memory care and was found on the second floor of the general population (certified separately). Staff did not hear the door alarm; kitchen staff cleared the alarm. Tenant #1 got onto the elevator and other tenants alerted staff of Tenant #1's location. Staff located Tenant #1 and he was easily redirected back to the memory care unit. Continued record review revealed Staff to Nurse Communication Forms, completed for staff statements related to the incident on 12/10/25 noted the following: a. Staff A indicated she was with another tenant and Staff A heard Staff B report over the walkie talkie at 7:40 a.m. Tenant #1 had eloped. Staff A said other tenants near the elevator told Staff A Tenant #1 was upstairs on the second floor. Staff B took the elevator and Staff A ran upstairs. Staff A met Staff B upstairs and Staff B found him near an apartment on the second floor. Tenant #1 was cooperative and returned to the memory care with staff. Staff A indicated the memory care door did not alarm. Staff A assumed Tenant #1 got out behind someone who had the code. Staff C reported he brought in food after Tenant #1	A 160		

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A 160	Continued From page 3 eloped. b. Staff B indicated she came out of a tenant's apartment, went to the dining room and culinary staff said that there was a "big guy" in the hallway. Staff B asked Staff A and Staff D via the walkie talkie if they saw Tenant #1 and both staff said no. Staff B ran to the hallway and other tenants were there and said Tenant #1 went on the elevator. Staff B went up the elevator, Staff A ran up the stairs and Tenant #1 was found by a tenant apartment (second floor). Tenant #1 came back with staff without difficulty. Staff B did not hear any door alarms from the door. c. Staff C indicated he went to clock in for work at 7:34 a.m. When he put his coat away in the back hallway he saw Tenant #1 standing in the lower level hallway by the elevator. The memory care door alarm was off and he cleared it. He went inside the memory care unit to find staff to let them know Staff C saw Tenant #1 in the hallway. Staff ran into the hallway and up the stairs to look for Tenant #1. Staff C went upstairs to look outside and make sure Tenant #1 did not get out and to help staff look for Tenant #1. Record review on 4/14/26 and 4/15/26 of Tenant #1's file revealed diagnoses included: cognitive impairment and moderate dementia without behavioral disturbance. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #1's most recent service plan was dated 11/19/25. The service plan reflected Tenant #1 wandered and made attempts to exit. He also wandered into other tenants' apartments. It indicated to not leave Tenant #1 unattended during active exit seeking.	A 160		

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A 160	Continued From page 4	A 160		

When interviewed on 4/14/26 at 1:00 p.m. Staff A reported she worked with possibly Staff B and Staff D. It was on the first shift and occurred early in the shift. Staff A thought she was the medication passer and was called to another tenant's apartment by Staff D. Staff A indicated it was very common for Tenant #1 to wear a coat and gloves. He was aware of the door as he left with family. Staff gave him coffee; he went to the apartment and came back with gloves. Staff A gave him a banana. Tenant #1 was seated at the table when she left to assist in the other tenant apartment. The other staff possibly, Staff B, (not sure) said kitchen staff came into the memory care unit to notify staff. Staff C clocked in and when in the break room he saw Tenant #1 in the common area. Staff C came into the unit to tell staff. Staff C notified Staff A via the walkie talkie. Staff A then walkied for everyone to look for him. Other tenants saw Tenant #1 get on the elevator. Staff B went on the elevator and Staff A took the stairs and walked the hallways on the first floor. Staff B found Tenant #1 at the end of the hallway on the second floor. Staff A went up to the second floor and Tenant #1 was asked to come with staff and get some coffee. Staff A indicated Tenant #1 did not leave the building and he was gone from the memory care unit less than five minutes. Tenant #1 did not sustain any injuries. Staff A reported now the door alarm came up on the pager and was audible. At that time it was audible but she did not hear it in the other tenant apartment. Staff A indicated regarding the no door alarm in her statement that she did not know Staff C had reset it.

When interviewed on 4/14/26 at 2:38 p.m. Staff B reported she thought it happened first shift between breakfast and lunch. She worked the first shift with Staff A. Staff B came out to the

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kitchen and Staff C told her the big guy left. Staff B was coming down to the dining room and Staff C told her. Staff B indicated Tenant #1 was always exit seeking but it was worse on the second shift. She saw other tenants who said Tenant #1 was on the elevator. Staff A took the stairs and Staff B ran to the first floor and went to the second floor. Tenant #1 was walking down the hallway on the second floor. Tenant #1 was agreeable to return to the unit with Staff B. He did not have any injuries and was not gone for more than three minutes. Staff B reported Tenant #1 was never in his apartment and staff always had eyes on him. He did not indicate he was going to leave prior to. She indicated now staff received a page regarding the door alarm; however, she did not think they had a pager notification at that time.

When interviewed on 4/14/26 at 10:23 a.m. Staff C reported he saw that person at the elevator, after that he thought it was a memory care tenant and went to memory care to tell staff. Staff ran to get him. Staff C did not recall information related to the door alarm.

Attempts were made to interview Staff D (who was no longer employed by the Program). The attempts were not successful.

Record review on 4/14/26 revealed reporting information in the self-report document to the Department revealed an internal investigation was started. Tenant #1 had hourly checks and it was documented he was last seen at 7:03 a.m. in the dining room by Staff B. Video footage revealed At 7:24 a.m. Tenant #1 returned to the dining room and was dressed in winter outside clothing, including coat, hat and gloves and carried a towel. He sat at the table with other

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A 160	Continued From page 6	A 160		

tenants and staff gave him a cup of coffee. He took off his gloves. At 7:28 a.m. all staff left the main dining room area. At 7:31 a.m. Staff D came back into the dining room area and interacted briefly with Tenant #1 before exiting the area. At 7:34 a.m. Tenant #1 put on gloves, put up his hood and walked out of the view of the camera towards the front memory care entrance door. At 7:35 a.m. Staff C entered the memory care unit through the main entrance door. Staff C looked around and down the memory care unit hallway and then went right back out of the unit. At 7:44 a.m. it was noted Tenant #1 returned to the unit with Staff B. The document indicated all staff on duty were verbally re-educated on the life safety and elopement policies and procedures. All staff (care staff and non-care staff) would be re-educated on life safety.

When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness reported she was on-call and was called after the elopement happened. Staff B brought him back and staff reported the alarms never went off. After reviewing the cameras, it was determined the alarms went off. Shortly after the elopement the Director of Health and Wellness arrived and followed up with Tenant #1, he was at his baseline and had no injuries. Review of the cameras indicated there was no staff in the dining area, Tenant #1 went to his apartment, returned with his coat, sat down and then walked out. It appeared Staff C saw him outside the memory care unit, Staff C came into the unit looked around and it was thought at that time Tenant #1 got on the elevator. Tenant #1 exited the view of the camera and it was assumed he got on the elevator. Staff B noticed he was missing and got on the walkie. Staff A and Staff B left the unit and looked for him. Tenant #1 did not leave the

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A 160	Continued From page 7 building. He was gone from the memory care unit for 10 minutes. The door alarms functioned. Staff were not in the common area when they were supposed to be. There should have been one person in the area. At that time the door alarms did not go to a pager and would have just been audible. Staff did not follow the service plan, if he was in an actively wandering state, not to leave him alone. She would have requested (staff) not leave the tenant. When interviewed on 4/16/26 at 12:29 p.m. the Executive Director reported he was notified of the elopement. Access to the cameras indicated Tenant #1 was at breakfast, he got up and put on work gloves. He got up and went towards the memory care door, the exit could not be seen. Tenant #1 exited and one minute, Staff C came through the door, heard the alarm, looked for staff, found one staff. Staff B found him on the second floor, Tenant #1 did not leave the building. He was gone for at most, five minutes. Tenant #1 did not sustain any injuries. He indicated care staff did not hear the alarm, now it had been upgraded and it notified the pager. Staff were verbally re-educated. The Director of Health and Wellness also re-educated staff regarding him putting on gloves and the potential.	A 160		
A 231	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a	A 231		

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A 231	Continued From page 8 human service professional, or a licensed practical nurse via nurse delegation. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations within 30 days of occupancy. This pertained to 1 of 1 tenant reviewed admitted in the last three months (Tenant #2). Finding follows: Record review on 4/15/26 of Tenant #2's file revealed Tenant #2 moved to the memory care unit on 3/7/26 from the general population (certified separately). Evaluations were completed on 3/6/26; however, were not completed within 30 days of occupancy in the memory care unit. When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness confirmed the above finding	A 231		
A 232	481-69.22(3) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation.	A 232		

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A 232	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 2 of 4 tenants reviewed (Tenant #2 and Tenant #4). Findings follow: 1. Record review on 4/15/26 of Tenant #2's file revealed Observations (nurse's notes) indicated the following: -On 3/18/26, Tenant #2's family requested a nutritional supplement or orange juice be given if she did not go to the dining room. A fax was sent to the primary care provider (PCP) to request an order for a nutritional supplement. Tenant #2's family member requested to be notified if Tenant #2 missed two meals in a row. -On 3/23/26, a signed order was received from the PCP for a nutritional supplement. Continued record review revealed Tenant #2's weights reflected a 16.2 pound weight loss from 3/24/26 to 4/14/26. Further record review revealed Tenant #2's evaluations were completed on 3/6/26. Evaluations were not completed as needed with the order for the nutritional supplement and the 16.2 pound weight loss. When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness confirmed there was not evaluations completed related to Tenant #2's weight loss. 2. Record review on 4/15/26 and 4/16/26 of Tenant #4's file revealed Observations (nurse's	A 232		

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A 232	Continued From page 10	A 232		

notes) indicated the following:

-On 4/6/26, the hospice nurse reported Tenant #4 was more lethargic and had not been eating and drinking as was previously. Family and hospice discussed letting Tenant #4 stay in bed and not pushing food and fluids unless requested by Tenant #4. Hospice was to increase visits due to Tenant #4's decline.

-On 4/8/26, Tenant #4 had not gotten out of bed today and had no oral intake. She was unable to take Tylenol (morning). Hospice made medication changes.

-On 4/8/26, new orders were received to discontinue scheduled and as needed Tylenol and to start morphine 20 milligram (mg)/milliliter (ml), take 0.25 ml (5 mg) by mouth every eight hours.

-On 4/10/26, new orders were received to discontinue eye drops and to increase morphine 0.25 ml, to every six hours scheduled and every two hours as needed.

-On 4/11/26, nursing was to complete a change of condition as Tenant #4 was nearing the end of life per hospice. Tenant #4 was no longer attending meals, getting dressed, wearing glasses or wearing partials (dentures).

-On 4/13/26, staff communication form dated 4/12/26 indicated hospice told staff to reposition every hour instead of every two hours.

-On 4/13/26, a change of condition assessment was completed. Tenant #4 had a general decline and was no longer getting out of bed and comfort medications were increased. Staff assisted with

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A 232	Continued From page 11 bathing/bed bath (as needed), dressing (as needed), hygiene, check and change (toileting assistance), repositioning and medications. Continued record review revealed evaluations were completed on 4/13/26; however, significant changes were noted to Tenant #4's condition starting on 4/6/26. 3. When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness indicated regarding the delay in Tenant #4's evaluations and service plans, that Tenant #4 was still getting up (prior to the update).	A 232		
A 280	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with rule 481-69.22(231C) and be designed to meet the specific needs of the individual tenant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans that reflected the specific needs of the tenants. This pertained to 2 of 4 tenants reviewed (Tenant #1 and Tenant #3). Findings follow: 1. Record review on 4/14/26 of Tenant #1's file revealed an incident report indicated on 12/10/25 Tenant #1 exited out of memory care and was found on the second floor of the general population (certified separately). Staff did not	A 280		

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A 280	Continued From page 12	A 280		

hear the door alarm, kitchen staff cleared the alarm. Tenant #1 got onto the elevator and other tenants alerted staff of Tenant #1's location. Staff located Tenant #1 and he was easily redirected back to the memory care unit.

Continued record review revealed the January to April 2026 Task Administration Records (TARs) reflected Tenant #1 had refusals of toileting assistance and bathing assistance.

Further record review revealed Tenant #1's most recent service plan was dated 11/19/25. The service plan reflected Tenant #1 wandered and made attempts to exit. He also wandered into other tenants' apartments. It indicated to not leave Tenant #1 unattended during active exit seeking. The service plan was not updated after Tenant #1 eloped on 12/10/25 to reflect that he eloped from the memory care unit and any additional interventions. The service plan also reflected staff assisted with bathing and toileting; however, did not reflect Tenant #1's refusals of those cares and interventions related to the care refusals.

2. Record review on 4/15/26 of Tenant #3's file revealed the January to April 2026 TARs reflected routine refusals of bathing, hygiene and grooming and toileting.

Continued record review of the January to April 2026 medication administration records (MARs) reflected an order to ensure the perineal area was clean, apply baby oil to the uterus (visible vaginally), twice daily. It indicated to notify nursing of consistent refusals and it was noted as important. The January to March 2026 MARs reflected refusals of the ordered treatment above.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0360	A. BUILDING: _____ B. WING _____	C 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN ALP/I	1275 W FOREVERGREEN ROAD NORTH LIBERTY, IA 52317

(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 280	Continued From page 13 Further record review revealed the Adult Services Monitoring Entrance Form (completed by the Program) identified Tenant #3 as a tenant who consistently refused personal and/or health related care. Continued record review revealed Tenant #3's service plan dated 3/18/26 reflected staff provided assistance with bathing, hygiene/grooming, dressing, and due to poor eyesight staff assisted with incontinence care. It indicated staff were to provide assistance with toileting and perineal care, to encourage Tenant #3 to use a pad instead of toilet paper in the protective brief. If Tenant #3 refused to complete a check of the protective brief to ensure it was clean and dry. It also indicated staff administered Tenant #3's medications. The service plan reflected Tenant #3 had a visible prolapsed uterus and to assist with keeping her perineal area clean. The service plan did not reflect Tenant #3's routine refusals of cares as noted above. When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness confirmed the above finding.	A 280		
A 282	481-69.26(3) Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. The service plan shall be signed by all parties, including the tenant or tenant's legal representative.	A 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 282	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans within 30 days and as needed with significant change. This pertained to 2 of 4 tenants reviewed (Tenant #2 and Tenant #4). Findings follow: 1. Record review on 4/15/26 of Tenant #2's file revealed Tenant #2 moved to the memory care unit on 3/7/26 from the general population (certified separately). Tenant #2's service plan was updated on 3/6/26; however, was not updated within 30 days of occupancy. Continued record review revealed Tenant #2's Observations (nurse's notes) indicated the following:' -On 3/18/26, Tenant #2's family requested a nutritional supplement or orange juice be given if she did not go to the dining room. A fax was sent to the primary care provider (PCP) to request an order for a nutritional supplement. Tenant #2's family member requested to be notified if Tenant #2 missed two meals in a row. -On 3/23/26, a signed order was received from the PCP for a nutritional supplement. Further record review revealed Tenant #2's weights reflected a 16.2 pound weight loss from 3/24/26 to 4/14/26. Continued record review revealed Tenant #2's service plan reflected to notify Tenant #2's family member if she missed two meals in a row. The service plan was not updated as needed to reflect the nutritional supplement or the 16.2 pound	A 282		

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A 282	Continued From page 15 weight loss as noted above. When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness confirmed the service plan was not updated within 30 days for Tenant #2. She also confirmed it was not completed with weight loss 2. Record review on 4/15/26 and 4/16/26 of Tenant #4's file revealed Observations (nurse's notes) revealed the following: -On 4/6/26, the hospice nurse reported Tenant #4 was more lethargic and had not been eating and drinking as was previously. Family and hospice discussed letting Tenant #4 stay in bed and not pushing food and fluids unless requested by Tenant #4. Hospice was to increase visits due to Tenant #4's decline. -On 4/8/26, Tenant #4 had not gotten out of bed today and had no oral intake. She was unable to take Tylenol (morning). Hospice made medication changes. -On 4/8/26, new orders were received to discontinue scheduled and as needed Tylenol and to start morphine 20 milligram (mg)/milliliter (ml), take 0.25 ml (5 mg) by mouth every eight hours. -On 4/10/26, new orders were received to discontinue eye drops and to increase morphine 0.25 ml, to every six hours scheduled and every two hours as needed. -On 4/11/26, nursing was to complete a change of condition as Tenant #4 was nearing the end of life per hospice. Tenant #4 was no longer attending meals, getting dressed, wearing glasses or	A 282		

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A 282	Continued From page 16 wearing partials (dentures). -On 4/13/26 it was noted staff communication form dated 4/12/26 indicated hospice told staff to reposition every hour instead of every two hours. -On 4/13/26, a change of condition assessment was completed. Tenant #4 had a general decline and was no longer getting out of bed and comfort medications were increased. Staff assisted with bathing/bed bath (as needed), dressing (as needed), hygiene, check and change (toileting assistance), repositioning and medications. Continued record review revealed Tenant #4's service plan was updated on 4/13/26; however, significant changes were noted to Tenant #4's condition starting on 4/6/26. When interviewed on 4/16/26 at 11:15 a.m. the Director of Health and Wellness indicated regarding the delay in Tenant #4's evaluations and service plans, that Tenant #4 was still getting up (prior to the update).	A 282		