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 |
|---|---|---|---|
| | S0361 | A. BUILDING: _____ B. WING _____ | C 03/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **COBBLESTONE COURT ASSISTED LIVING** | **3187 140TH STREET SUMNER, IA 50674** |

| (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 |
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| A 000 | Initial Comments<br><br>Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site.<br><br>Tenants without cognitive impairment: 31<br><br>Tenants with cognitive impairment: 0<br><br>Total census: 31<br><br>Regulatory insufficiencies were cited during the investigation of Complaint # 130764-C.<br><br>231C.16A Medication setup - administration and storage of medications.<br><br>2. If medications are administered or stored by an assisted living program, or if the assisted living program provides for medication setup, all of the following shall apply:<br><br>b. Medications, other than those self-administered by the tenant or provided through medication setup, shall be stored in locked storage that is not accessible to persons other than employees responsible for administration or storage of medications.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on interview and record review, the Program failed to ensure medications for 1 out of | A 000 | | |

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

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2 tenants were stored in locked storage not accessible to anyone other than persons responsible for medication administration (Tenant #1). Finding follows:

Record review on 3/12/26 revealed Tenant #1's file indicated an admission date of 10/26/22. Tenant #1's service plan dated 3/26/25 revealed the following information regarding medication administration: Staff administered medications as ordered by the physician on the medication administration record (MAR). The medications were kept in a locked cabinet in Tenant #1's apartment. Tenant #1 managed as needed (PRN) medications and over-the-counter medications independently and stored these medications at her own discretion.
Tenant #1's MAR for December 2025 revealed the following medications were crushed, mixed into applesauce and administered at 5:00 p.m. daily: Dorzolamide Timolol Maleate Hcl 22.3 milligrams (mg)/6.8 mg eye drops - one drop to each eye, Eliquis 2.5 mg - one tablet, Venlafaxine HCL 50 mg - one tablet, and Vitamin D3 50 mcg - one tablet.

When interviewed on 3/12/26 at 2:13 p.m., the Administrator confirmed non-certified staff had assisted in the administration of medications in the past. The Administrator revealed Staff A handed Resident #1 her 5:00 p.m. medications during one incident when Resident #1 returned to the Program after 5:00 p.m. The Administrator revealed she prepared the cup of medications and locked them into Resident #1's medication cabinet and Staff A later only had to hand the medications to Resident #1. The Administrator left the Program prior to Resident #1 returning from her outing. The Administrator confirmed Staff A obtained the keys for the locked

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medication cabinet from the office wall where they hung for staff. The Administrator admitted she had not considered at the time of the incident that part of the administration of medications was when Staff A handed the medications to Resident #1 and observed her ingest them. The Administrator added Staff A was not a medication manager at the time of the medication administration.

When interviewed on 3/12/26 at 2:35 p.m., the Registered Nurse confirmed the medication cabinet keys hung on the office wall and anyone certified or non-certified had access to those keys.

When interviewed on 3/12/26 at 2:48 p.m., Staff A confirmed she handed Resident #1 medications once in December of 2025. Staff A indicated prior to the Administrator leaving the Program she prepared Resident #1's medications in advance and locked them into her medication cabinet. Staff A reported she unlocked the medication cabinet, took the cup of crushed pills and added applesauce. Staff A handed the cup of pills and eye drops to Resident #1 and she took the pills and administered the eye drops on her own. Staff A confirmed she accessed the medication cabinet keys from the office wall where they hung. Staff A added she became a medication manager in February of 2026.

When interviewed on 3/12/26 at 3:30 p.m., the Administrator and the Registered Nurse confirmed the medication cabinet keys were hung on a hook in the staff office where both certified and non-certified staff had access to them.

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| A 270 | Continued From page 3 | A 270 | | |
| A 270 | 481-67.5(2)f(1) Medications<br><br>67.5(2) Each program shall follow its own written medication policy, which shall include the following:<br><br>f. When medications are administered traditionally by the program:<br><br>(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).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the Program failed to ensure only staff who had completed a department-approved medication manager course administered medications to tenants. This affected 1 of 2 tenants reviewed (Tenant #1). Finding follows:<br><br>Record review on 3/12/26 revealed Tenant #1's file indicated an admission date of 10/26/22. Tenant #1's service plan dated 3/26/25 revealed the following information regarding medication administration: Staff administered medications as ordered by the physician on the medication | A 270 | | |

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| A 270 | Continued From page 4 | A 270 | | |

administration record (MAR). The medications were kept in a locked cabinet in Tenant #1's apartment. Tenant #1 managed as needed (PRN) medications and over-the-counter medications independently and stored these medications at her own discretion.

Tenant #1's MAR for December 2025 revealed the following medications were crushed, mixed into applesauce and administered at 5:00 p.m. daily: Dorzolamide Timolol Maleate Hcl 22.3 milligrams (mg)/6.8 mg eye drops - one drop to each eye, Eliquis 2.5 mg - one tablet, Venlafaxine HCL 50 mg - one tablet, and Vitamin D3 50 mcg - one tablet.

When interviewed on 3/12/26 at 2:13 p.m., the Administrator confirmed non-certified staff assisted in the administration of medications in the past. The Administrator revealed Staff A handed Tenant #1 her 5:00 p.m. medications during one incident when Tenant #1 returned to the Program after 5:00 p.m. The Administrator revealed she prepared the cup of medications and locked them into Tenant #1's medication cabinet and Staff A later only had to hand the medications to Tenant #1. The Administrator left the Program prior to Tenant #1 returning from her outing. The Administrator confirmed Staff A obtained the keys for the locked medication cabinet from the office wall where they hung for staff. The Administrator admitted she had not considered at the time of the incident that part of the administration of medications was when Staff A handed the medications to Resident #1 and observed her ingest them. The Administrator added Staff A was not a medication manager at the time of the medication administration.

When interviewed on 3/12/26 at 2:35 p.m., the

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| A 270 | Continued From page 5<br><br>Registered Nurse agreed she had not considered if a non-certified staff member took medications from a locked medication cabinet and administered the prepared medications to a resident, it was part of the administration process.<br><br>When interviewed on 3/12/26 at 2:48 p.m., Staff A confirmed she handed Tenant #1 medications once in December of 2025. Staff A indicated prior to the Administrator leaving the Program she prepared Tenant #1's medications in advance and locked them into her medication cabinet. Staff A reported she unlocked the medication cabinet, took the cup of crushed pills and added applesauce. Staff A handed the cup of pills and eye drops to Tenant #1 and she took the pills and administered the eye drops on her own.<br>Staff A confirmed she accessed the medication cabinet keys from the office wall where they hung. Staff A added she became a medication manager in February of 2026.<br><br>When interviewed on 3/12/26 at 3:30 p.m., the Administrator and the Registered Nurse confirmed a non-certified staff had participated in medication administration for one resident. | A 270 | | |