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
	S0463	A. BUILDING: _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARSTONE SENIOR LIVING	4715 ALGONQUIN DRIVE CEDAR FALLS, IA 50613

(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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 53 Number of tenants with cognitive impairment: 0 Total census: 53 The following regulatory insufficiencies were cited during the investigation of Complaint #122780-C, Incident #122793-I, Incident #126079-I and the recertification visit conducted to determine compliance with certification of an Assisted Living Program.	A 000		
A 410	481-67.19(3)b Record Checks 67.19(3)b Conducting a background check. The program may access the single contact repository (SING) to perform the required background check. If the SING is used, the program shall submit the person's maiden name, if applicable, with the background check request. If SING is not used, the program must obtain a criminal history check from the department of public safety and a check of the child and dependent adult abuse registries from the department of human services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure child and dependent adult abuse record checks were completed prior to employment for 7 of 7 employee files reviewed (Staff F through L). Findings follow:	A 410	The Plan of Correction is attached	

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

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A 410	Continued From page 1 Employee record review on 2/18/25 revealed the following: - Staff F was hired on 2/13/25. A Background Screeners of America background check dated 1/28/25 failed to include child and dependent adult abuse checks. - Staff G was hired on 1/16/25. A Background Screeners of America background check dated 1/9/25 failed to include child and dependent adult abuse checks. - Staff H was hired on 1/2/25. A Background Screeners of America background check dated 12/6/24 failed to include child and dependent adult abuse checks. - Staff I was hired on 12/19/24. A Background Screeners of America background check dated 12/9/24 failed to include child and dependent adult abuse checks. - Staff J was hired on 11/13/24. A Background Screeners of America background check dated 11/5/24 failed to include child and dependent adult abuse checks. - Staff K was hired on 10/3/24. A Background Screeners of America background check dated 9/18/24 failed to include child and dependent adult abuse checks. - Staff L was hired on 9/12/24. A Background Screeners of America background check dated 9/5/24 failed to include child and dependent adult abuse checks. No checks of the child and dependent adult abuse registries from the department of health and human services could be located. When questioned, the Executive Director replied via email on 2/19/25 at 10:31 am and acknowledged the child and adult abuse checks had not been completed prior to employment.	A 410		

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A 410	Continued From page 2 On 2/20/25 at 10:15 am the Executive Director and Director of Wellness confirmed these findings.	A 410		
A 435	481-67.19(5) Record Checks 67.19(5) Employment prohibition. A person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a program unless an evaluation has been performed by the department of human services. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to obtain an evaluation from the Department of Health and Human Services (DHHS) prior to employment for 1 of 1 staff reviewed with a criminal history (Staff G). Finding follows: Employee record review on 2/18/25 revealed Staff G was hired 1/16/25. The Background Screeners of America background check dated 1/9/25 revealed a criminal history. An evaluation from HHS determining whether the crime warranted prohibition of Staff G's employment could not be located. When questioned, the Executive Director replied via email on 2/18/25 at 10:45 am and stated the program had no DHHS evaluation letters as the program did not hire anyone with anything on their backgrounds. On 2/20/25 at 10:15 am the Executive Director and Director of Wellness confirmed these	A 435		

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A 435	Continued From page 3 findings.	A 435		
A 430	481-69.27(1)c 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 shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to assess and document the health status of 1 of 5 tenants reviewed (Tenant 2). Findings follow: Record review on 2/19/25 revealed Tenant 2 admitted to the program on 4/1/24 with a diagnosis of Type 1 Diabetes Mellitus. A service plan for Tenant 2 last reviewed 11/12/24 revealed Tenant 2 required assistance with medication administration and management, and assistance with diabetic care. The program self-reported an incident on 1/14/25 and indicated Tenant 2 had an incident on 1/11/25 and noted the following incident summary (copied as written): Resident spoke to community staff about blood sugars being elevated her Dexcom read "high". Med aide assisted resident with	A 430		

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A 430	Continued From page 4	A 430		

traditional accucheck (400). Care partners reported to on duty LPN Change of condition in resident (needing to be escorted to the dining room, and resident dragging left foot), along with elevated blood sugar. Community staff spoke to Family on elevated blood sugar, family requested vitals be taken on the resident (pulse 69, B/P 189/80). Community nurse admitted to not following up on concern of residents change of condition, and not communicating anything other than the high blood sugars. Residents Family transported resident to Mercy one ER where resident was admitted to the ICU with 2 brain bleeds.

A review of program documentation on 2/18/25 for Tenant 2 revealed a late entry nursing progress note dated 1/11/25 by the Director of Wellness indicated the following note text (coped as written):

-The RN on call was notified via text that the resident was being taken to the ER by family for elevated blood sugars. Med Partner reported that the resident's PM blood sugar reading before supper was HIGH. The Med Partner escorted the resident back to her room to obtain fingerstick results instead of using the Dexcom, and noted that the resident appears to be dragging her left foot. The resident's fingerstick also showed a "HIGH" reading. The resident's daughter, who monitors blood sugars from home, had contacted Med Partner. Insulin was administered as ordered, and Med Partner notified the LPN on shift about the concerns. Med Partner also recorded the resident's blood pressure as 189/80 with a pulse of 69. Family arrived after supper, and the granddaughter took another blood pressure reading. Given the elevated blood sugars and left-sided weakness, the family decided it was best for the resident to be seen in

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A 430	Continued From page 5 the ER. A follow-up nursing progress note dated 1/13/25 indicated the program called the hospital to obtain an update on Tenant 2 and the program was informed Tenant 2 had been transferred from the emergency room to another hospital to an Intensive Care Unit (ICU) due to a brain bleed, but had discharged from the ICU and was receiving continued care on the medical floor. The program's internal investigation further revealed Medication Partner (Staff A) had appropriately alerted the Nurse as to Tenant 2's condition, but the Nurse failed to assess Tenant 2 or provide any instruction to the staff. During an interview on 2/19/25 at 10:11am, Staff B stated she was the Care Partner on duty on 1/11/25. Staff B stated Tenant 2 pressed her pendant and alerted her of the high blood sugar reading from the Dexcom. Staff B alerted Medication Partner Staff A. Staff B stated she helped to escort Tenant 2 after dinner and noticed Tenant 2 had an abnormal gait. Staff B stated she was present in the apartment when Staff A alerted the LPN about the tenant's high blood sugar reading and condition and stated Staff A made the decision to contact Tenant 2's family. Staff B stated she couldn't recall the LPN ever coming to assess Tenant 2. During an interview on 2/19/25 at 10:52am, Staff A stated she was the Medication Partner on duty on 1/11/25. She stated she had checked Tenant 2's Dexcom blood sugar reading at lunch time, noted it was 400mg/dL, administered insulin in accordance with Tenant 2's Medication Administration Record (MAR) and adjusted the insulin amount per the tenant's sliding scale, and	A 430		

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A 430	Continued From page 6	A 430		

notified the LPN. Staff A stated Tenant 2 later pressed her pendant towards dinner time and it was noted the Dexcom was again showing "high." Staff A stated she checked the blood sugar again and noted it to be at 400. She escorted Tenant 2 to the dining room and Tenant 2 stated her foot felt like it was dragging. Staff A stated she alerted the LPN again. She and Staff B escorted Tenant 2 back to her apartment after dinner. Staff A stated she spoke with the family of Tenant 2 and provided an update. Staff A alerted the LPN again. The LPN never came to assess Tenant 2.

During an interview on 2/19/25 at 12:25 pm, Tenant 2 recalled the incident on 1/11/25 and confirmed her Dexcom was showing "high" and staff then took additional blood sugar test and it showed a result of 400. She stated it felt like her left foot seemed like it was dragging. She stated the LPN never came to assess her. Her daughter and granddaughter are both nurses and arrived and transported her to the hospital and she was told by the hospital she had a brain bleed.

Further review of the program's internal investigation revealed an emailed statement dated 1/21/25 from the LPN confirmed she had been notified multiple times by Staff A about Tenant 2's high blood sugars and her change in gait on 1/11/25. Per the statement, she planned on going to assess Tenant 2 but her family had already arrived. Per the statement, the LPN then confirmed Staff A called her a third time to alert her Tenant 2's family was transporting her to the hospital.

During an interview on 2/19/25 at 2:10 pm the Director of Wellness stated with Tenant 2's high blood sugars and staff reports of an abnormal gait the LPN should have gone to Tenant 2 and

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A 430	Continued From page 7 assessed her and documented the tenant's condition. On 2/20/25 at 10:15 am the Executive Director and Director of Wellness confirmed these findings.	A 430		
A 530	481-69.29(4) Staffing 481-69.29(231C) Staffing. 69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans. A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to check on tenants as indicated in each tenant's service plan for 1 of 1 former tenants reviewed (Tenant C1). Findings follow: Record review on 2/19/25 revealed Tenant C1 admitted to the program on 2/16/24. A Change of Condition nursing assessment dated 3/14/24	A 530		

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A 530	Continued From page 8	A 530		

completed by the Director of Wellness indicated Tenant C1 was at a risk for falls. A Fall Risk Assessment included as part of the assessment utilized the Morse Fall Scale and revealed a risk score of 90 pts on a scale of 0-125 pts, indicating High Risk 45 and higher. The fall risk assessment further indicated Tenant C1 had an impaired gait with difficulty rising from a chair, cannot walk unassisted, dizziness, impairment on one side for upper extremity, impairment on both side for lower extremities, and a history of falls. The nursing assessment indicated Tenant C1 required an assistance of 1 for transfers and needed hands on assist to go from sit to stand as well as maintain balance from stand to sit, and needed physical assist of 1 staff for ambulation.

A document entitled "Unscheduled Services" indicated in June of 2024 Tenant C1 experienced increased difficulty in transfers, ambulation and showering and required occasional assistance from two staff. A service plan for Tenant C1 with last review completed 7/22/24 identified the fall risk and revealed the program implemented a focus area of Status Checks on 6/20/24 with the following goal "I will have consistent monitoring checks." The service plan further identified Tenant C1 required assistance with (but not limited to) continence needs.

While a review of nursing progress notes did not reveal record of an incident and a program incident report was not provided, the program self-reported an incident dated 8/15/24 in which Tenant C1's family reported to the program Tenant C1 was observed lying on the floor of her apartment as seen on cameras placed in the tenant's apartment. Family also noted staff had not provided status checks as required during the overnight hours of the 7:00 pm to 7:00 am shift

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A 530	Continued From page 9 from 8/14/24 to 8/15/24. Upon notification by the family staff responded and observed Tenant C1 on the floor and proceeded to render aid. The program's internal investigation following the incident revealed a temporary staffing agency employee (Staff E) failed to provide the required two-hour checks during her shift on 8/14/24 ending on the morning of 8/15/24 as indicated in the service plan. The program's internal investigation revealed Tenant C1 had last been checked on at approximately 8:45 pm on the evening of 8/14/24. On 2/18/24 a review of Activities of Daily Living (ADLs) task and interventions revealed Tenant C1 required Status Checks during the day and on the overnight at 2:00 am and 6:00 am. She further required toileting continence assistance and had a staff-assisted toileting schedule to be completed at 8:00 am, 10:00 am, 12:00 pm, 2:00 pm, 12:00 am, and 4:00 am to ensure and maintain independence where possible, dignity, and hygiene. No status checks were documented as completed at 2:00 am or 6:00 am on the morning of 8/15/24 as required. Additionally, no toileting checks were documented as completed at 12:00 am or 4:00 am on the morning of 8/15/24 as required. During an interview on 2/18/25 at 11:30 am Staff D confirmed he was the staff working on the morning of 8/15/24 and had received a call from the family of Tenant C1 who informed him she was on the floor. He responded and entered Tenant C1's apartment, saw her on the floor and alerted the nurse per protocol so the tenant could be appropriately assessed. Tenant C1 had soiled herself and additionally her shirt was wet. Staff D confirmed Tenant C1 had a staff-assisted toileting	A 530		

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A 530	Continued From page 10 schedule and it should have been followed during the overnight hours. Staff D stated Tenant C1 would not have been able to voice her toileting needs which was why the toileting schedule was important. During an interview on 2/29/25 at 2:20 pm, the Director of Wellness confirmed Tenant C1 was service planned for both status checks (described as a physical check between cares) and a toileting schedule, as most of Tenant C1's falls had included incontinence and she couldn't necessarily verbalize her toileting needs. The Director of Wellness reviewed the ADLs task documentation and stated she didn't believe Staff E completed the required checks. On 2/20/25 at 10:15 am the Executive Director and Director of Wellness confirmed these findings.	A 530		

PLAN OF CORRECTION		
Provider/Supplier Name:	Cedar Stone Senior Living	
Street Address, City, Zip:	4715 Algonquin Dr Cedar Falls, IA 50613	
Date of Survey:	February 17, 2025 to February 20,2025	
Cedar Stone Senior Living Cert No.		**S0463**
ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency cited are correctly applied. Any changes to the community policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies.	
481-67.19(3)b	**Correction of Cited Deficiency:**	2.25.25

Record Checks	Business office Director will complete a history check of the child and dependent adult abuse registry on all existing employees, and on going on new employees.	
481-67.19(3)b Record Checks	**Assessment to Identify other Residents that may be affected:** No residents have been affected by this Cited Deficiency.	2.25.25
481-67.19(3)b Record Checks	**Procedure to ensure on-going compliance:** Business Office Director will not set up any new employee with orientation until both the criminal history check from the department of public safety and a check of the child and dependent adult abuse registry has been completed with results returned to the community.	2.25.25
481-67.19(3)b Record Checks	**Monitoring for on-going compliance:** Business Office Director will discuss new hires on a weekly basis with Executive Director and discuss where they are in the background process prior to setting up the employee for orientation.	3.10.25

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481-67.19(5) Record Checks	**Correction of Cited Deficiency:** Business office Director will complete a history check of the child and dependent adult abuse registry on all existing employees, and ongoing on new employees. Any employee who has committed a crime or has a record of founded child or dependent adult abuse will not be employed but Cedar Stone Senior Living with out a evaluation preformed but the department of human services. Business Office Director will complete the evaluation process for Staff G by the department of human services. If not approved to work by then department of human services Staff G will no longer be employed by Cedar Stone	2.25.25

	Senior Living effective immediately after results are received.	
481-67.19(5) Record Checks	**Assessment to Identify other Residents that may be affected:** No residents have been affected by this Cited Deficiency.	2.25.25
481-67.19(5) Record Checks	**Procedure to ensure on-going compliance:** Business Office Director will not set up any new employee with orientation until both the criminal history check from the department of public safety and a check of the child and dependent adult abuse registry has been completed with results returned to the community. If employee has a Criminal or abuse result, then the community will either not go forward with hiring the individual or will complete the evaluation process by the department of human services.	3.10.25
481-67.19(5) Record Checks	**Monitoring for on-going compliance:** Business Office Director will work with the Executive Director to when a employee has a criminal or abuse background to determine if employing the employee is desired, if employment is desired the Community will not offer employment with out completing the evaluation process and approval from the department of human services.	3.10.25

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Street Address, City, Zip:	4715 Algonquin Dr Cedar Falls, IA 50613
Date of Survey:	February 17, 2025 to February 20,2025

Cedar Stone Senior Living Cert No.		S0463
ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency cited are correctly applied. Any changes to the community policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies.	
481-69.27(1)c Nurse Review	**Correction of Cited Deficiency:** Community placed nurse on duty at the time of the incident on suspension effective immediate pending results of the investigation. Employee was to be terminated due to lack of follow up or resident assessment leading delayed treatment of the resident the employee had given her notice, and the community accepted the employees notice. The Employee admitted to lack of follow up on her end led to delay of treatment. Community Reeducated all Wellness staff on change of condition and when to not follow chain of command and	1.20.25

	call the RN on call for evaluation to prevent delay in treatment in the future.	
481-69.27(1)c Nurse Review	**Assessment to Identify other Residents that may be affected:** When advised of incident Director of Wellness confirmed there were no other issues with any other residents.	1.11.25
481-69.27(1)c Nurse Review	**Procedure to ensure on-going compliance:** Wellness staff has been reeducated to on change of condition and when not to follow chain of command and notify the RN on call for evaluation of a resident with change of condition. RN on call is posted in the community where staff can easily locate.	1.20.25
481-69.27(1)c Nurse Review	**Monitoring for on-going compliance:** Director or Wellness, Resident Care Coordinator, and Executive Director are all on a thread to discuss on call issues pertaining to residents where all issues are discussed.	1.11.25

PLAN OF CORRECTION		
Provider/Supplier Name:	Cedar Stone Senior Living	
Street Address, City, Zip:	4715 Algonquin Dr Cedar Falls, IA 50613	
Date of Survey:	February 17, 2025 to February 20,2025	
Cedar Stone Senior Living Cert No.		**S0463**

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481-69.29 (231c) Staffing	**Correction of Cited Deficiency:** Community had changed the orientations process for agency staff members. Community also placed the agency staff member as a "Do Not Return" who did not carry out the care detailed in the resident's care plan.	8.15.24
481-69.29 (231c) Staffing	**Assessment to Identify other Residents that may be affected:** Executive Director verified charting, and no other resident did was affected by this citation. All other care was charted for all other residents within the community during date in question.	8.15.24

	Education provided to all staff on the importance of notifying supervisor if they cannot get into point of care app.	
481-69.29 (231c) Staffing	**Procedure to ensure on-going compliance:** Community has changed the orientation policy for agency staff that they must sign off on understanding where to find the care detailed for all residents as well as how to chart for care provided.	8.25.24
481-69.29 (231c) Staffing	**Monitoring for on-going compliance:** Director or Wellness and Resident Care Coordinator will verify charting compliance regularly and will follow up with staff on care not charted. Directo of Wellness and Resident Care Coordinator will educate and document education with Staff members who fail to chart. Disciplinary action will be taken for care not provided.	8.25.24

√ 5/21/25