Iowa Department of Inspections, Appeals, and Licensing
Health & Safety Division
Adult Services Civil Penalty Citation

Date: October 7, 2026
Program Name: Friesland Assisted Living and Zeeland Memory Care
Address: 1742 Main Street Pella, IA 50219
Type of Action: Recertification Visit and Investigation #131938-I
Date(s) of Action: 9/14/26-9/16/26
Citation #11270

State Rule #		Amount of Civil Penalty
Iowa Administrative Code 481 Chapter 67.3(2)	**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.** Based on interview and record review, the program failed to ensure tenants received adequate and appropriate care, treatment, and services for 1 of 4 tenants reviewed (Tenant #C1). Finding follows: Record review on 9/14/26 revealed an incident report dated 4/17/26, indicated Tenant #C1 was observed on the floor of her bathroom at 9:00am. The report indicated Tenant #C1 was lying on her right side and a pack of wipes was near her head with fecal matter on it, and fecal matter was on the floor and on Tenant #C1's inner thighs. Tenant #C1 was observed guarding her left hip and grimacing and was unable to move. Tenant #C1 was able to state "fell" and expressed pain by touching her head and hip when questioned about any pain. Program staff called the ambulance for assistance and Tenant #C1 was transported to the emergency room. Review on 9/14/26 of a nurses note dated 4/17/26 entered under the category of "x-orders-administration note" noted a confirmed fractured hip and Tenant #C1 would not be returning to the program and had been admitted to a hospice house. Continued record review on 9/14/26 and 9/15/26 revealed: a. Tenant #C1 admitted to the program 11/13/25. A Global Deterioration Scale (GDS) assessment dated 4/8/26 indicated Tenant #C1 had a GDS score of six (severe cognitive decline). The program completed a significant change comprehensive evaluation/nurse review on 4/8/26 and indicated Tenant #C1 demonstrated a significant decline in condition, noted increased	**$5000.00**

	incontinence had been observed, overall presentation indicated marked functional and behavioral decline, and a hospice admit. A nurses note dated 4/9/26 further included (but not limited to) "increased care needs, now requiring up to two-person assist at time for transfers and toileting", "assist with ADLs (Activities of Daily Living) as tolerated and accepted," and "Visual checks every two hours day and night." b. April 2026 Activity of Daily Living task sheets 9/15/26 for Tenant #1 instructed program staff to provide assistance with the following (but not limited to) tasks: - Offer toilet every two hours, check and change prn, provide peri cares with each incontinent episode. - Safety Check: Resident is checked every two hours during day and hour of sleep (HS) c. The service plan completed 4/9/26 noted Tenant #C1 requested to be woken up at night to toilet or change incontinence products, but failed to identify staff were to offer the toilet every two hours and provide peri cares with each incontinent episode as identified as a task/support/support action on the task sheets. The service plan failed to address Tenant #C1's need for occasional 2-person assistance for transfers/toileting and failed to identify the every two-hour visual check needs as indicated by the 4/9/26 nurses note. During an interview on 9/15/26 at 3:00pm, Staff B reviewed the task sheet documentation and indicated she forgot to document. She explained when she first started, no one showed her she needed to document it, and documentation was a struggle for her and continued to be so, but acknowledged the program provided phones, tablets, or a laptop computer to document. During an interview on 9/15/26 at 5:22pm, Staff F acknowledged she didn't always document because she was by herself at night. She indicated she was told staff didn't need to wake people up just to go to the bathroom, but if a tenant was awake, then they can, but stated sometimes tenants get upset. She acknowledged staff needed to do two-hour visual/safety checks to "check that they're not dead", but stated she didn't always document because the computer didn't always work for her because of the internet. Staff F indicated she knew she needed to document before 6:00am because after 6:00am, the computer automatically wouldn't allow her to document, so documented right before she left her shift. Staff F explained some tenants have every two hour checks and some had an hour, especially if mobility was declining, but failed to	

	specifically recall the needs of Tenant #C1. Staff F indicated some tenants don't know how to use the call light. Staff F expressed that she had 16 people to check on. When asked if she provided any checks on the overnight shift prior to Tenant #C1's fall with fracture on 4/17/26, Staff F replied it would have depended on what else happened on her shift that night. During an interview 9/16/26 at 1:17pm, Staff G indicated visual/safety checks began around 7:00am on her shift and stated Tenant #C1 was not a very "wakeable" person. On the morning of 4/17/26 Staff F from the overnight shift asked Staff G if Staff G wanted Staff F to check on Tenant #1 before she left the shift. Staff G declined and said they would complete the check. Staff G indicated she was only aware of Tenant #C1's visual/safety check, but was not aware of Tenant #C1's every two-hour toileting check, and believed Tenant #C1 was independent with toileting but occasionally had "a mess." Staff G explained she knew what tasks she had done and that documentation hadn't started until May 2026 in Point Click Care and prior to that, communications were passed to the next shift by word of mouth. Staff G indicated the task sheets should show who documented and edited the tasks. During an interview on 9/15/26 at 1:53pm and 3:19pm, the Administrator (ADM) acknowledged there was lack of documentation of the care-related tasks for Tenant #C1 for the time period reviewed.	