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
	S0090	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

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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: 0 Tenants with cognitive impairment: 11 Total census: 11 The following regulatory insufficiencies were cited related to the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	A 000		
A 145	481-69.22(3) 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 when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as	A 145		

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A 145	Continued From page 1	A 145		

needed with a significant change. This pertained to 2 of 3 tenants reviewed (Tenant #1 and Tenant #2). Findings follow:

1. Record review on 12/04/25 of Tenant #1's file revealed Progress Notes indicated the following:

a. On 11/06/25, staff was in another tenant's apartment, heard a noise and found Tenant #1 on the floor in the hallway. She was laying on her back with her head against the wall, and she was pale and clammy. She was assisted up; she was not able to stand and was lowered to the floor by staff. A "lump" was present on the back of her head. Tenant #1's family and 911 were called. She was taken to a hospital.

b. On 11/06/25, a new order was received for cefdinir (antibiotic) 300 milligrams (mg), one capsule twice daily for seven days.

c. On 11/06/25, Tenant #1's primary care provider (PCP) was notified via fax regarding Tenant #1's diagnosis of a urinary tract infection (UTI) and new order for cefdinir 300 mg, twice daily for seven days. It indicated she was to be seen by the PCP in one week.

Continued record review revealed a Nurse Review dated 11/06/25 indicated Tenant #1 had an unwitnessed fall on 11/05/25 at 8:45 p.m., was weak, pale and transported to the hospital. She was diagnosed with a UTI and prescribed cefdinir 300 mg, twice daily for seven days. It indicated a discretionary change to the service plan, staff was to assist with perineal care, assist with changing her incontinent brief and to encourage water throughout the day.

Further record review revealed Tenant #1's

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service plan noted she wore her own underwear and to monitor if she needed assistance. The plan indicated she was independent with the use of a toilet. The service plan reflected a prior history of UTIs. On 11/06/25 the service plan was updated with her diagnosis of a UTI, was more incontinent, had been wearing briefs, and staff encouraged her to let them help with toileting. It was noted she was expected to return to baseline after the antibiotic was completed.

Continued record review revealed the November 2025 medication administration record (MAR) reflected cefdinir 300 mg was administered from 11/06/25 (p.m. dose) to 11/13/25 (a.m. dose) and it was completed.

Further record review revealed evaluations were last completed on 10/24/25. The service plan was updated on 11/06/25 with the changes noted above and a nurse review was completed; however, the changes made to the service plan were not minor or discretionary and evaluations were not completed as required.

When interviewed on 12/04/25 at 4:4 6 p.m. the Unit Director indicated interventions were added to the service plan to assist with perineal care, manage her briefs and before she had not required toileting assistance. She said evaluations were not completed as it was expected she would get back to her baseline. She confirmed the antibiotic was completed. She said it was hit and miss with toileting assistance and at times she went independently. Staff checked on her more frequently, mainly overnight.

2. Record review on Record review on 12/04/25 of Tenant #2's file revealed Progress Notes indicated the following:

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A 145	Continued From page 3 a. On 10/06/25, Tenant #2 would not take her medication and said she was too tired. b. On 10/06/25, Tenant #2 did not eat breakfast and her insulin was held. c. On 10/07/25, Tenant #2 did not eat supper. Her oral medications and insulin were held. d. On 10/08/25, Tenant #2 did not get out of bed all day. e. On 10/10/25, Tenant #2 told staff she was not ready to get up and wanted to sleep more. She said she would take her medications later. f. On 10/10/25, Tenant #2 had been sleeping more and not getting up until late afternoon. A few times her speech was not coherent. An assessment indicated pupils were equal, reactive and she had equal grips at those times. She refused her medications, was not eating and her blood glucose readings were low. Insulin was being held. The PCP was notified of the above. g. On 10/13/25, Tenant #2 was still in bed and did not eat breakfast. h. On 10/14/25, Tenant #2 was more lethargic and would answer when a question was asked. i. On 10/15/25, Tenant #2 would not get out of bed or take her medications. j. On 10/22/25, Tenant #2 was still asleep and refused medication. She did not eat breakfast and her insulin was held. k. On 10/22/25, Tenant #2 was still in bed (1:48 p.m. nurse's note) would not sit up to take her medications. l. On 10/25/25, a fax was sent to the PCP regarding Tenant #2 continuing to be very lethargic, not wanting to get out of bed, at times upset and crying then other times in a good mood but did not want to get up. After she was up, she acted very tired. A request was made for labs. m. On 10/27/25, orders were received for labs. n. On 11/05/25, she was sleeping and	A 145		

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A 145	Continued From page 4 medications were not administered. o. On 12/01/25, she refused to get up or take her medications. p. On 12/01/25, Tenant #2 did not get out of bed today. q. On 12/03/25, her morning blood glucose was 65 and insulin was held Continued record review revealed evaluations were last completed on 9/17/25. Tenant #2's service plan, updated on 12/03/25 reflected Tenant #2 refused to get out of bed and had bouts of nausea and decreased appetite. It also reflected she liked to sleep in often and staff was to check and change her and allow her to sleep in. Evaluations were not completed related to issues above and the service plan updated on 12/03/25. When interviewed on 12/04/25 at 4:46 p.m. the Unit Director reported Tenant #2 had done that ever since she had been there. Sometimes Tenant #2 would stay in bed for a day or two. She did it repeatedly. It was normal behavior for her. On 12/03/25 the service plan was updated to reflect if she was sleeping to re-approach. She confirmed all evaluations were completed for the tenants reviewed. It should be noted although indicated as normal behavior for Tenant #2 In the interview, it was not documented on her service plan until 12/03/25.	A 145		
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	A 350		

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A 350	Continued From page 5 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 service plans as needed, based on evaluations, and reflect the service needs of the tenants. This pertained to 2 of 3 tenants reviewed (Tenant #1 and Tenant #2). Findings follow: 1. When interviewed on 12/04/25 at approximately 8:25 a.m. the Unit Director reported Tenant #1 wandered into other tenant apartments. She was not physically aggressive and lately had not gone to the exit doors. When interviewed on 12/04/25 at 10:31 a.m. Staff A indicated Tenant #1 wandered throughout the building but did not seek an exit. Tenant #1 was looking for her spouse. She was very redirectable. When interviewed on 12/04/25 at 10:42 a.m. Staff B said Tenant #1 wandered around a bit and got into things and books. Record review on 12/04/25 of Tenant #1's file revealed the service plan indicated Tenant #1 wandered into other tenants' apartments and was seen to redirect her with snacks and to redirect back to her apartment. The service plan did not	A 350		

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reflect this behavior and interventions until 12/01/25.

2. Record review on 12/04/25 of Tenant #1's file revealed Progress Notes indicated the following:

a. On 11/06/25, staff was in another tenant's apartment, heard a noise and found Tenant #1 on the floor in the hallway. She was laying on her back with her head against the wall, and she was pale and clammy. She was assisted up; she was not able to stand and was lowered to the floor by staff. A "lump" was present on the back of her head. Tenant #1's family and 911 were called. She was taken to a hospital.

b. On 11/06/25, a new order was received for cefdinir (antibiotic) 300 milligrams (mg), one capsule twice daily for seven days.

c. On 11/06/25, Tenant #1's primary care provider (PCP) was notified via fax regarding Tenant #1's diagnosis of a urinary tract infection (UTI) and new order for cefdinir 300 mg, twice daily for seven days. It indicated she was to be seen by the PCP in one week.

Continued record review revealed a Nurse Review dated 11/06/25 indicated Tenant #1 had an unwitnessed fall on 11/05/25 at 8:45 p.m., was weak, pale and transported to the hospital. She was diagnosed with a UTI and prescribed cefdinir 300 mg, twice daily for seven days. It indicated a discretionary change to the service plan, staff was to assist with perineal care, assist with changing her incontinent brief and to encourage water throughout the day.

Further record review revealed Tenant #1's service plan noted she wore her own underwear

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and to monitor if she needed assistance. The plan indicated she was independent with the use of a toilet. The service plan reflected a prior history of UTIs. On 11/06/25 the service plan was updated with her diagnosis of a UTI, was more incontinent, had been wearing briefs, and staff encouraged her to let them help with toileting. It was noted she was expected to return to baseline after the antibiotic was completed.

Continued record review revealed the November 2025 medication administration record (MAR) reflected cefdinir 300 mg was administered from 11/06/25 (p.m. dose) to 11/13/25 (a.m. dose) and it was completed.

Further record review revealed evaluations were last completed on 10/24/25. The service plan was updated on 11/06/25 with the changes noted above and a nurse review was completed; however, the changes made to the service plan were not minor or discretionary and evaluations were not completed as required.

When interviewed on 12/04/25 at 4:4 6 p.m. the Unit Director indicated interventions were added to the service plan to assist with perineal care, manage her briefs and before she had not required toileting assistance. She said evaluations were not completed as it was expected she would get back to her baseline. She confirmed the antibiotic was completed. She said it was hit and miss with toileting assistance and at times she went independently. Staff checked on her more frequently, mainly overnight.

3. Record review on Record review on 12/04/25 of Tenant #2's file revealed Progress Notes indicated the following:
a. On 10/06/25, Tenant #2 would not take her

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medication and said she was too tired.
b. On 10/06/25, Tenant #2 did not eat breakfast and her insulin was held.
c. On 10/07/25, Tenant #2 did not eat supper. Her oral medications and insulin were held.
d. On 10/08/25, Tenant #2 did not get out of bed all day.
e. On 10/10/25, Tenant #2 told staff she was not ready to get up and wanted to sleep more. She said she would take her medications later.
f. On 10/10/25, Tenant #2 had been sleeping more and not getting up until late afternoon. A few times her speech was not coherent. An assessment indicated pupils were equal, reactive and she had equal grips at those times. She refused her medications, was not eating and her blood glucose readings were low. Insulin was being held. The PCP was notified of the above.
g. On 10/13/25, Tenant #2 was still in bed and did not eat breakfast.
h. On 10/14/25, Tenant #2 was more lethargic and would answer when a question was asked.
i. On 10/15/25, Tenant #2 would not get out of bed or take her medications.
j. On 10/22/25, Tenant #2 was still asleep and refused medication. She did not eat breakfast and her insulin was held.
k. On 10/22/25, Tenant #2 was still in bed (1:48 p.m. nurse's note) would not sit up to take her medications.
l. On 10/25/25, a fax was sent to the PCP regarding Tenant #2 continuing to be very lethargic, not wanting to get out of bed, at times upset and crying then other times in a good mood but did not want to get up. After she was up, she acted very tired. A request was made for labs.
m. On 10/27/25, orders were received for labs.
n. On 11/05/25, she was sleeping and medications were not administered.
o. On 12/01/25, she refused to get up or take her

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medications.
p. On 12/01/25, Tenant #2 did not get out of bed today.
q. On 12/03/25, her morning blood glucose was 65 and insulin was held

Continued record review revealed evaluations were last completed on 9/17/25. Tenant #2's service plan, updated on 12/03/25 reflected Tenant #2 refused to get out of bed and had bouts of nausea and decreased appetite. It also reflected she liked to sleep in often and staff was to check and change her and allow her to sleep in. Evaluations were not completed related to issues above and the service plan updated on 12/03/25.

Further record review revealed the Medication Review Report indicated an order to crush medications or substitute liquid if difficulty swallowing. The service plan reflected staff administered her medications; however, did not reflect that medications were crushed.

When interviewed on 12/04/25 at 4:46 p.m. the Unit Director said Tenant #2 had done that ever since she had been there. She said sometimes she would stay in bed for a day or two. She did it repeatedly. It was normal behavior for her. On 12/03/25 the service plan was updated to reflect if she was sleeping to re-approach. She confirmed the service plan did not reflect crushed medications.

It should be noted although indicated as normal behavior for Tenant #2 in the interview, it was not documented on her service plan until 12/03/25.