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
	S0151	A. BUILDING: _____ B. WING _____	C 03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CENTERVILLE	19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544

(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 impairment: 25 Tenants with cognitive impairment: 10 Total census: 35 The following regulatory insufficiencies were cited during the investigation of Incident 131124-I and Complaint #131132-C.	A 000		
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. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the Program failed to consistently ensure tenants received appropriate services related to medication administration. This pertained to 1 of 2 tenants reviewed (Tenant #1). Finding follows: Record review on 2/24/26 revealed Tenant #1's Incident Report (IR), dated 12/30/25, documented Tenant #1's medications discontinued due to miscommunication with family regarding a change in pharmacy. The Program's contracted	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0151	A. BUILDING: _____ B. WING _____	C 03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CENTERVILLE	19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544

(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 160	Continued From page 1	A 160		

pharmacy sent communication to the Program listing Tenant #1's medications were discontinued.

During an interview on 2/24/26 at 12:50 p.m., the family member reported she took Tenant #1 to her physician and informed the physician she preferred to use a local pharmacy. The physician sent the prescriptions to the local pharmacy. The family member reported she picked up the medications and delivered them to a staff member at the Program. The family member could not recall the staff member's name.

When interviewed on 2/25/26 at 11:45 a.m., the Director/former nurse indicated she observed a bag of medications in Tenant #1's apartment when Tenant #1 moved to memory care on 12/27/25. The Director reported she returned the medications to the pharmacy without investigating why the medications were present in Tenant #1's locked medication area.

Record review on 2/26/26 of Tenant #1's Service Plan (SP), signed 10/28/25, directed staff would continue to administer Tenant #1's medications.

Further record review on 2/26/26 revealed the Program failed to administer the following medications according to Tenant #1's Medication Administration Record (MAR) as agreed upon in the Service Plan:

- Cardizem LA 180 milligrams (mg) once daily for paroxysmal atrial fibrillation from 12/19/25 through 12/31/25

- Levothyroxine Sodium 25 micrograms (mcg) once daily for postprocedural hypothyroidism from 12/19/25 through 12/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0151	A. BUILDING: _____ B. WING _____	C 03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CENTERVILLE	19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544

(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 160	Continued From page 2 - Zoloft 50 mg once daily for depression from 12/19/25 through 12/30/25 - Eliquis five mg twice daily for paroxysmal atrial fibrillation from 12/19/25 through 12/30/25 in the morning - Metoprolol Tartrate 25 mg twice daily for essential hypertension from 12/18/25 through 12/30/25 in the morning - Buspirone HCL five mg three times daily for anxiety disorder from 12/01/25 through 12/30/25 in the morning During an interview on 2/25/26 at 11:45 a.m., the Director confirmed she received notification from the Program's pharmacy partner the above medications had been discontinued. She contacted the physician's office but failed to follow up. The medications were removed from the MAR as current medications. The Director reported Tenant #1's Power of Attorney (POA) for health care indicated a desire to discontinue use of the contracted pharmacy and transfer prescriptions to a local pharmacy. She confirmed she became aware of a bag of medications from the local pharmacy in Tenant #1's medication area only when Tenant #1 moved to memory care on 12/27/25. The Director acknowledged the discontinuation resulted from miscommunication and confirmed staff should have communicated regarding the medications rather than placing them in the locked medication cabinet where they went unnoticed.	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0151	A. BUILDING: _____ B. WING _____	C 03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CENTERVILLE	19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544

(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 635	Continued From page 3	A 635		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the Program failed to ensure an operating door alarm was connected to and functioning with each exit door. This pertained to 1 of 1 tenant identified in Incident 131124-I (Tenant #1). Finding follows: Record review on 2/24/26 revealed Tenant #1's Incident Report (IR), dated 12/25/25 documented an elopement. Staff noted Tenant #1's walker near the front entrance. Staff searched the area and located Tenant #1 outside behind the building. Staff assisted Tenant #1 back into the building. During an interview on 2/25/26 at 1:45 p.m., Staff A reported she arrived at work and observed another staff member attempting to redirect Tenant #1 away from the front door. Staff A reported she heard the door alarm from the office area and observed Tenant #1 pushing on the door bar. Staff A entered the door code and pulled the door closed in an attempt to latch it. Tenant #1 continued pressing on the door two to three additional times. Staff A indicated no other staff were present in the area and she had not yet obtained a communication device (walkie-talkie or phone). Staff A reported she pulled the door closed, assumed it had latched, and went to the office to retrieve a walkie-talkie. When she	A 635		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0151	A. BUILDING: _____ B. WING _____	C 03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CENTERVILLE	19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544

(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 635	Continued From page 4	A 635		

returned, she observed Tenant #1's walker near the door but could not locate Tenant #1. Staff A indicated the alarm did not sound. Staff A initiated a search of the building before going outside. She returned inside to check additional areas and attempted to contact Staff B without success. A nurse then entered the area and requested all staff search for Tenant #1. Staff B subsequently located Tenant #1 on the north side of the building looking at horses.

Observations on 3/02/26 revealed the distance from the front door to the area where Staff B located Tenant #1 measured approximately 0.12 miles across the Program's parking lot. Review of Weather Underground data for 12/25/25 at 1:55 p.m. revealed the temperature was 46 degrees Fahrenheit with no precipitation. During an interview on 3/02/26 at 1:15 p.m., Staff B recalled Tenant #1 wore jeans, a sweater, socks, and shoes. Staff B reported Tenant #1 indicated she was cold and wanted to return inside.

During an interview on 3/02/26 at 12:30 p.m., the former Director confirmed Tenant #1 wore a Wandergard bracelet. She indicated if the door system had been properly engaged and functioning, the door would have locked when Tenant #1 approached it. The former Director reported Staff A received a disciplinary write-up for leaving the area while Tenant #1 actively attempted to exit the building. Review of the Program's Electronic Surveillance Systems Policy (no date) revealed when a Wandergard transmitter approached an exit, the door should lock. The former Director confirmed if the door had been properly closed and latched, the locking mechanism would have engaged.

Record review on 3/02/26 revealed an Employee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0151	A. BUILDING: _____ B. WING _____	C 03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CENTERVILLE	19999 ST JOSEPH'S DRIVE CENTERVILLE, IA 52544

(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 635	Continued From page 5 Disciplinary Action Record for Staff A documented Staff A attempted to redirect Tenant #1 unsuccessfully, left the area to obtain a walkie-talkie, and Tenant #1 exited the building. Record review on 3/02/26 revealed Tenant #1's Global Deterioration Scale score of four indicated a moderate cognitive decline. Tenant #1 had a history of elopement attempts, including several prior attempts before leaving the building at approximately 1:55 p.m. on 12/25/25. Tenant #1 wore a Wandergard bracelet due to these prior elopement attempts. Tenant #1 sustained no injuries during the elopement. Tenant #1 was missing for approximately three minutes. During the exit on 3/02/26 at 2:30 p.m., the administrative team confirmed staff failed to ensure the door latched properly and the alarm and locking mechanism did not function when Tenant #1 exited the building on 12/25/25 at approximately 1:55 p.m.	A 635		