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
	S0045	A. BUILDING: _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD ASSISTED LIVING	2501 W STATE STREET MASON CITY, IA 50401

(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. General Population Program Number of tenants without cognitive disorder: 28 Number of tenants with cognitive disorder: 3 TOTAL census of Assisted Living Program for People with Dementia: 31 No regulatory insufficiencies were cited during the investigation of Complaint #112611-C. The following regulatory insufficiencies were cited during the Investigation of #114386-A, #114391-M, #114389-A and #114408-C:	A 000	POC 2/1/24	
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans to identify individual needs and preferences. This pertained to 1 of 1 tenants reviewed as a result of Incident #114391-M (Tenant #1). Findings follow: Record review of Tenant #1's file on 7/2/23 noted diagnoses of cerebral ischemia due to a	A 395	Service plans will be completed on or before admission, within 30 days of admission, annually and with a significant change. Tenant #1 is now discharged. Compliance will be monitored by Executive Director or designee on a routine basis. Date of compliance is 2/1/24.	

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

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A 395	Continued From page 1	A 395		

traumatic brain injury, unspecified dementia, cognitive deficits, cortical blindness on right and left side of her brain, epilepsy and alcohol abuse.

Tenant #1's Service Plan dated 6/2/23 revealed she demonstrated a lack of judgment related to safety, wore a wanderguard, and required hourly checks. She needed staff to provide cues to ensure safety due to mild to moderation disorientation or difficulty retaining information.

On 7/27/23 at 2:37 p.m. Tenant #2 confirmed he gave the code to Tenant #1 for the door to the courtyard located by his apartment. He stated they often went outside to sit in the courtyard together.

On 7/27/23 at 2:10 p.m. Tenant #1 admitted she climbed over the fence in the courtyard to walk to a restaurant to have a glass of wine but could not recall how she exited the building. She stated she was upset with her sister and wanted to get away.

During an interview on 7/26/23 at 3:17 p.m. the Administer confirmed some tenants had the codes to the doors to come and go as they wished to allow them independence. She said Tenant #2 had the code and he would sit outside with Tenant #1. She stated Tenant #1 no longer used a wanderguard for several months as she found ways to remove it and had no exit seeking behavior prior to the current elopement. Tenant #1's sister purchased her tokens to use community transportation to visit friends and volunteer at a community kitchen. The Administrator acknowledged they failed to update Tenant #1's service plan to include that information.