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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
	S0186	A. BUILDING: _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF OSKALOOSA MC	2102 S MARKET ST OSKALOOSA, IA 52577

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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. Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 11 TOTAL census of Assisted Living Program: 11 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program for People with Dementia. Regulatory insufficiencies were cited during the investigation into Incident #113847-I and Incident #111988-I.	A 000	POC 8/1/23	
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 interview and record review, the facility failed to provide appropriate services to 1 of 3 current tenants reviewed (Tenant #2). Findings follow: Record review of progress notes on 7/17/23	A 160	Additional staff training was provided on 6-23-23 to ensure the doors are fully closed when exiting the prosaram and to look behind to make sure tenants are not following behind the staff.	6-23-23

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 160	Continued From page 1 revealed the Resident Care Coordinator (RCC) received a call from staff at approximately 2:56 PM on 6/22/23 informing her they could not find Tenant #2. Staff looked in all of the rooms and courtyards. At 2:57 PM, the RCC received a call from the facility doctor asking if Tenant #2 was in the facility, because he believed she was at a convenience store located close to the facility (0.2 miles). The RCC drove to the convenience store and Tenant #2 willingly got into her vehicle. Tenant #2 stated she left the program because she was upset and needed to get out and go for a walk. She had no shortness of breath when conversing. The RCC completed a physical assessment when they returned to the program and found no sign of injury. Tenant #2 denied falling. Her clothing did not have any signs of grass or debris. Her vitals were within normal parameters. Her skin was pink, warm and dry. Her walk was at a normal gait. Tenant #2 was an 81 year old female with a moderate cognitive decline with diagnoses including hearing loss, dementia with unspecified severity, psychotic disturbance, anxiety and hypertension (high blood pressure). On 7/18/23 the Executive Director provided a video of Tenant #2 leaving the building. Staff A left the building at 2:01:09 PM with garbage in her hands and Tenant #2 sat on a sofa close to the exit door. Tenant #2 exited through the door before it fully closed at 2:01:26 PM. Staff A returned to the building at 2:02:32 and another resident met her at the door and attempted to tell her Tenant #2 left through the door, but due to her limited verbal skills, Staff A did not understand what was communicated and did not investigate any further. The Executive	A 160	This will be included in routine Staff training and monitored by executive director or designee.	

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A 160	Continued From page 2 Director reported this was an area staff received further education on following the incident. On 7/13/23 at 9:55 AM Staff A reported Tenant #2 sat on the couch before she went out the door. She stated she did not realize it took 10 seconds for the exit door to latch after it closed and now knows to listen for the sound of the latch and watch for the keypad to turn red. On 7/17/23 at 4:20 PM, Staff B stated she came in to work and Staff A reported what happened on her shift. It was probably 15-20 minutes later when Staff A took the garbage out the back door and Tenant #2 eloped. Staff B would probably have been at the nurse's station where she could not see the exit door. On 7/19/23 at 10:00 AM, the RCC stated staff are delegated about how to prevent elopement and included looking behind them when they lock the door. Staff A would have received this training (a review of employee documentation revealed Staff A completed her orientation training on 5/24/23). Staff were retrained on both of these topics following the elopements. An elopement drill was completed. In addition, staff received orientation training on locking doors which included watching for tenants coming out behind them in the secured areas of the building. She confirmed Staff A did not follow expected training related to monitoring doors in the memory care area. According to Wunderground.com, the weather in Oskaloosa on 6/22/23 at 2:00 PM was 89 degrees with no precipitation.	A 160		
A 385	481-69.26(3)d Service Plans	A 385	Provider's Plan of Correction	8-1-2023

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A 385	Continued From page 3 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. d. The service plan updated within 30 days of the tenant's occupancy shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to update initial service plans within 30 days for 2 of 3 current tenants reviewed (Tenant #1 and Tenant #2). Findings follow: Record review on 7/13/23 revealed Tenant #1 moved to the program on 4/9/23. The program did not update his service plan until 5/25/23. Tenant #2 moved to the program on 5/9/23. The program did not update her service plan until 6/23/23. The Resident Care Coordinator confirmed these findings on 7/19/23 at 1:45 PM.	A 385	The Negotiated Service Agreement will be reviewed and, if necessary revised according to the following requirements: upon admission, within 30 days of admission, annually, and following a significant change in condition. Audits will be completed routinely per Executive Director or designee.	
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	A 395	Provider's Plan of Correction The Negotiated Service Agreement will be reviewed, and if necessary revised according to the following requirements	8-1-2023

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A 395	Continued From page 4 by: Based on interview and record review, the program failed to address identified needs on the service plans of 3 of 5 current and discharged tenants (Tenant #1, Tenant C1 and Tenant C2). Findings follow: 1. Record review of progress notes on 7/17/23 revealed the Registered Nurse (RN) received a call from staff on 3/28/23 at 7:47 PM reporting Tenant C2 was on the floor near the doorway of Tenant C1's room on her left side with her head between the dresser and wall. Tenant C2 was unable to tell staff how she came to be on the floor, but reported her head hurt. Tenant C2 refused any vitals. Tenant #3 was in the room and reported Tenant C2 tripped. Tenant C2 was wearing socks but no shoes and was last seen by staff at approximately 7:20 PM sitting on a sofa in the common room. Tenant C2 appeared to have increased pain with attempts to change position. Tenant C2's power of attorney agreed with a transfer to the emergency room. The RN updated the notes at 11:18 PM reflecting Tenant C2 was admitted to the hospital for a left hip fracture. The Resident Care Coordinator (RCC) reviewed video of the incident on 3/29/23 with the Executive Director. The video was no longer available at the time of the investigation. Prior to the incident, Tenant C1 walked out of her room and yelled at Tenant #3, who was sitting on a chair. When Tenant C1 returned to her room, she saw Tenant C2 get out of her bed and walk across the room. Neither resident was visible from the video camera, but a verbal altercation was heard, ending with what sounded like Tenant C2 moaning. At that time, Tenant #3 went to the doorway and asked what was going on there.	A 395	Upon admission, within 30 days of admission, annually, and following a significant change in condition. Audits will be completed routinely per Executive Director or designee.	

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A 395	Continued From page 5 She was seen batting her arms and hands with Tenant C1. She then walked away saying she was going to call the police. Staff were seen entering the room. Tenant C1 remained in the apartment while staff assisted Tenant C2 who was laying on the floor. A review of hospital records revealed Tenant C2 received surgery for a closed intertrochanteric fracture of her left hip. Following a hospitalization from 3/28/23 - 4/7/23, Tenant C2 moved to a skilled nursing facility. A. Tenant C2 had a Change of Condition physical evaluation completed on 7/11/22. According to the evaluation, Tenant C2 was disoriented and wandered. An Elopement Risk scale noted Tenant C2 had a history of wandering, verbalized a desire to exit the facility, "wanders", exhibits behavioral symptoms and is not easily directed, and is exit seeking or requests to go home. There was no updated evaluation after this date indicating Tenant C2's condition had changed. Tenant C2 had a service plan dated 7/11/22 which did not address her wandering. B. Tenant C1 had a service plan dated 10/8/22. Updates to her plan on that date added interventions related to her behavior. Staff were to remove Tenant C1 from situations where she displayed increased agitation. Her level of anxiety could increase causing her to pace, wander into other tenant's rooms, disrobe, and display violent/aggressive behavior toward staff and other tenants. Staff were to offer redirection. Following this service plan update, Tenant C1 had the following incidents according to a review of incident reports and progress notes:	A 395		

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A 395	Continued From page 6 - A 90-day review on 1/11/23 identified three aggressive acts over the prior three months. One involving a tenant in the dining room without injuries in which she hit a tenant on the arm, according to an earlier progress note. Tenant C1 also hit another tenant in the back. A third incident without injury was listed. - On 1/15/23 it was noted Tenant C1 continued to have aggression toward other tenants. Another tenant reported Tenant C1 smacked her. - On 2/8/23, Tenant C1 followed staff out of the memory care unit into the assisted living unit. Attempts to return Tenant C1 to the memory care unit were unsuccessful and she became increasingly agitated. Tenant C1 left the property with staff following her. The RCC received a prescription for 0.5 ml Haldol to administer to Tenant C1 to help calm her. 911 was called to assist with the process. Tenant C1 hit and bit staff. Tenant C1 agreed to return to the building when she saw the police officer. She received the medication and remained in the staff vehicle until she was fully calm. - On 2/25/23, Tenant C1 struck and yelled at another tenant and struck the tenant with a pool noodle several times. The other tenant hit Tenant C1 with a folder twice. Neither tenant had any injuries. - On 3/14/23, Tenant #3 went into Tenant C1's room. The tenants became upset and started slapping each other. No injuries were noted. - On 3/26/23, Tenant C1 opened the door to the shower room when another tenant was receiving a shower from staff. Tenant C1 stepped on the staff member's foot. Staff were able to get Tenant C1 out of the room with difficulty. A short time later, Tenant C1 walked to the front desk area and exchanged words with another tenant who threw her chair cushion at Tenant C1. Tenant C1 followed the tenant and staff to the	A 395		

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A 395	Continued From page 7 dining room where Tenant C1 continued yelling and using threatening language. No updates were made to Tenant C1's service plan to address her aggression toward other tenants from 10/8/22 until after the incident resulting in Tenant C2's hip fracture on 3/28/23. On 7/17/23 at 4:20 PM, Staff I reported they did not hear a fuss or commotion on 3/29/23. The building was carpeted and it was hard to hear. Tenant C2 was known to wander and enter people's rooms. Tenant C1could have good or bad days. She could be aggressive toward other residents. Over time this turned into physical aggression. Changes in routine would throw Tenant C2 off. On 7/17/23 at 2:00 PM, Staff J stated Tenant C1 did not like to have others in her room. Tenant C2 was known to wander throughout the building. She did not know if Tenant C1might have pushed Tenant C2 to get her out of her room. Tenant C1 would do things like throw her food at others she was angry at them. 2. Tenant #1 had a 30-day service plan dated 5/25/23. It noted Tenant #1 was independent with mobility, transfers and bed mobility. He used a walker for mobility. Staff were to remind Tenant #1 to use his assistive device as he might forget to use it. - Staff found Tenant #1 laying on his right side on 6/5/23 at 6:38 PM. His walker was in reach but upside down. He had no outward signs or symptoms of injury. Fall follow-up performed by nursing staff. - On 6/22/23, Tenant #1 was walking in the dining room without his walker and fell to his knees. He had mild redness to his knees but no other injury	A 395		

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A 395	Continued From page 8 was noted. Fall follow-up performed by nursing staff. - The RN noted on 6/26/23, Tenant #1 continued with poor safety awareness due to his advancing dementia, continue with routine follow up after fall per facility protocol. - On 6/27/23, the RN went to do a follow-up on Tenant #1 and found him on the floor laying on his left side at the bedside with his walker at his feet. He was plugging and unplugging recliner cords into the surger protector. He said he got down to work on the chairs. - Fall follow-up noted on 6/28/23. Tenant #1 is independent with transfers and ambulation. Staff should supervise Tenant #1 when he displayed increased weakness or improper use of his walker. His gait is slow, shuffling with noted unsteadiness with turns and doorways. - The RCC noted on 7/5/23 the Physical Therapist reported Tenant #1 was not safe ambulating independently. He was unstable and did not not respond to verbal cues. Staff were informed he needed standby assistance with a gait belt while ambulating. The program did not update Tenant #1's service plan to reflect he was no longer independent with mobility. The Executive Director, RN and RCC confirmed these findings on 7/19/23 at 1:45 PM.	A 395		