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
	S0222	A. BUILDING: _____ B. WING _____	C 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTEIN SENIOR LIVING	**1500 SOUTH KIEL HOLSTEIN, IA 51025**

(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: 12 Tenants with cognitive impairment: 3 Total census: 15 No regulatory insufficiencies were cited during the investigation of Incidents #130586-I, #130587-I, #130910-I and Complaint #131023-C. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia.	A 000		
A 215	481-69.24(1)a Involuntary Transfer from Program 69.24(1) Program initiation of transfer. If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply: a. The program shall notify the tenant or tenant's legal representative, in accordance with the occupancy agreement, of the need to transfer the tenant and of the reason for the transfer and shall include the contact information for the office of long-term care ombudsman. This REQUIREMENT is not met as evidenced by:	A 215		

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A 215	Continued From page 1	A 215		

Based on interview and record review, the Program failed to notify the tenant or tenant's legal representative, in accordance with the occupancy agreement of the need transfer, and reason for the transfer of the tenant for 2 of 5 former tenants reviewed (Tenant #C1 and Tenant #C2). Findings follow:

Record review on 2/11/26 revealed the following:

1. Tenant #C1 admitted to the Program on 6/23/25. A progress note dated 10/01/25, indicated the Program's Director and the Director of Nursing (DON) called Tenant #C1's daughter discussed a 30-day notice of termination of contract and noted the daughter expressed frustration. A progress note dated 10/06/25, indicated "30-day notice was given on 10/02/25."

2. Tenant #C2 admitted to the Program on 8/06/25. A progress note dated 10/01/25, indicated the Program's Director called Tenant #C2's daughter and "alerted daughter that we will be giving a 30-day termination of contract. Daughter expresses much frustration in communication upon acceptance of resident."

Review of an Occupancy Agreement (version effective March 2025) directed the following procedure upon termination of the contract: "The community will send discharge notice via certified mail to Resident/Responsible Party. Discharge notice will be a part of the resident file and provided to the Long-Term Care Ombudsman at 510 E. 12th Street, Rm 2, Des Moines, Iowa 50319. The Resident's treating physician, if applicable, will also be notified of the discharge notice."

On 2/12/26, the Regional Director of Operations

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A 215	Continued From page 2 (RDO) responded via email at 10:52 a.m. she was searching through past Executive Director and RDO files to locate the requested discharge notices for Tenant #C1 and Tenant #C2. At 11:25 a.m. the Regional Nurse Specialist confirmed the Program was not able to locate any discharge notices which indicated Tenant #C1 and Tenant #C2 and/or their respective representative received notice via certified mail of the discharge or were provided contact information for the Long-Term Care Ombudsman, and it didn't appear any notices had been issued. On 2/12/26 at 11:45 a.m., the Executive Director, the Regional Nurse Specialist and the Regional Director of Operations confirmed the above findings.	A 215		
A 220	481-69.24(1)b Involuntary Transfer from Program 69.24(1) Program initiation of transfer. If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply: b. The program shall immediately provide to the office of long-term care ombudsman, by certified mail, a copy of the notification and notify the tenant's treating physician, if any. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to provide notice to the office of	A 220		

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A 220	Continued From page 3	A 220		

the long-term care ombudsman, by certified mail, a copy of the notification and notify the tenant's treating physician for 2 of 5 former tenants reviewed (Tenant #C1 and Tenant #C2). Findings follow:

Record review on 2/11/26 revealed the following:

1. Tenant #C1 admitted to the Program on 6/23/25. A progress note dated 10/01/25, indicated the Program's Director and the Director of Nursing (DON) called Tenant #C1's daughter discussed a 30-day notice of termination of contract and noted the daughter expressed frustration. A progress note dated 10/06/25, indicated "30-day notice was given on 10/02/25."

2. Tenant #C2 admitted to the Program on 8/06/25. A progress note dated 10/01/25, indicated the Program's Director called Tenant #C2's daughter and "alerted daughter that we will be giving a 30-day termination of contract. Daughter expresses much frustration in communication upon acceptance of resident."

Review of an Occupancy Agreement (version effective March 2025) directed the following procedure upon termination of the contract: "The community will send discharge notice via certified mail to Resident/Responsible Party. Discharge notice will be a part of the resident file and provided to the Long-Term Care Ombudsman at 510 E. 12th Street, Rm 2, Des Moines, Iowa 50319. The Resident's treating physician, if applicable, will also be notified of the discharge notice."

On 2/12/26, the Regional Director of Operations responded via email at 10:52 a.m. she was searching through past ED and RDO files to

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A 220	Continued From page 4 locate the requested discharge notices for Tenant #C1 and Tenant #C2. When interviewed on 2/12/26 at 11:25 a.m. the Regional Nurse Specialist confirmed the Program was not able to locate any discharge notices which indicated the Long-Term Care Ombudsman had received notification of the discharge via certified mail or Tenant #C1's and Tenant #C2's respective treating physicians had been notified of the discharge notice, and stated it didn't appear any notices had been issued. On 2/12/26 at 11:45 a.m., the Executive Director, the Regional Nurse Specialist and the Regional Director of Operations confirmed the above findings.	A 220		
A 370	481-69.26(3)a Service Plans 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. a. If a significant change triggers the review and update of the service plan, the updated service plan 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 ensure service plans related to significant change were signed and dated by all parties for 4 of 5 tenants reviewed (Tenant #C1, Tenant #C2, Tenant #4, and Tenant #5). Findings follow:	A 370		

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A 370	Continued From page 5 Record review on 2/11/26 revealed: 1. Tenant #C1 admitted to the Program 6/23/25. The Program completed a comprehensive evaluation on 9/30/25. A progress note dated 9/30/25 revealed the evaluation was initiated due to a change of condition. A corresponding service plan was signed and dated with an incorrect date of 10/01/26 by the Program's Director of Nursing and the Regional Nurse Specialist, but failed to include a written signature of the resident or resident's responsible party and instead included a handwritten notation "verbal - POA daughter (name) 10/1/26". A copy of the Durable Power of Attorney for Health Care Decisions document for Tenant #C1 revealed the daughter of Tenant #C1 was not a designated agent/power of attorney. 2. Tenant #C2 admitted to the Program on 8/06/25. The Program completed a change of condition comprehensive evaluation on 10/01/25. A corresponding service plan was signed and dated 10/01/25 by the Program's Director of Nursing and the Regional Nurse Specialist, but failed to include a written signature of the resident or resident's responsible party and instead included a handwritten notation "verbal - POA daughter (name) 10/1/25." 3. Tenant #4 admitted to the Program on 10/13/21. The Program completed a change of condition comprehensive evaluation on 1/08/26. A corresponding service plan was signed and dated 1/08/26 by the Program's Director of Nursing and the Regional Nurse Specialist, but failed to include a written signature of the resident or resident's responsible party and instead included a handwritten notation "verbal - POA daughter (name) 1/8/26".	A 370		

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A 370	Continued From page 6 4. Tenant #5 admitted to the Program on 1/26/18. The Program completed a change of condition comprehensive evaluation on 1/30/26. A corresponding service plan was signed and dated 2/02/26 by the Program's Director of Nursing and the Regional Director of Operations, but failed to include a written signature of the resident or resident's responsible party and instead included a handwritten notation "verbal - POA (name) 2/2/26." Review of the Program's policy entitled "Service Plan" with an effective/revised date of 5/15/24 noted: The resident, and/or the resident's designated responsible person or legal representative if requested by the resident will sign the service plan. All persons involved in the development of the service plan will also sign the plan. The Registered Nurse (RN) and/or Director will review the service plan annually or with change of status and sign it with the resident and/or the resident designated responsible person or legal representative, if requested by the resident. During an interview on 2/12/26 at 9:55 a.m., the Regional Nurse Specialist acknowledged the service plans lacked the required written signatures of the tenant or the tenant's representative. She indicated some family representatives might be out of town or hard to reach. She reported the Program received education approximately one month prior which addressed how to send out hard copies of the service plans by mail to try and get the needed signatures. On 2/12/26 at 11:45 a.m., the Executive Director, the Regional Nurse Specialist and the Regional Director of Operations confirmed the above	A 370		

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A 370	Continued From page 7 findings.	A 370		
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 ensure service plans were individualized and accurately addressed needs for 1 of 5 tenants reviewed (Tenant #5). Finding follows: Record review on 2/11/26 revealed Tenant #5 admitted to the Program on 1/26/18. An entrance form provided by the Program identified no tenants received hospice services. Review of Tenant #5's service plan, dated 2/02/26 indicated Tenant #5 received outside services from hospice. Tenant #5 admitted into hospice on 11/04/24 for HTN (hypertension) heart disease with heart failure per the hospice/ palliative plan of care. On 2/12/26 at 10:42 a.m. the Regional Nurse Specialist responded via email Tenant #5 was discharged from hospice on 12/16/25 and a change of condition was completed but the Program failed to note the discontinuation of hospice services on the service plan. The Regional Nurse Specialist indicated she corrected the service plan during the onsite visit to reflect	A 395		

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A 395	Continued From page 8 the change. On 2/12/26 at 11:45 a.m., the Executive Director, the Regional Nurse Specialist and the Regional Director of Operations confirmed the above findings. .	A 395		