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
	S0233	A. BUILDING: _____ B. WING _____	C 11/25/2025

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HOMESTEAD OF CHARITON	1110 NORTH 6TH STREET CHARITON, IA 50049

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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 visit. Tenants without cognitive impairment: 32 Tenants with cognitive impairment: 2 Total census: 34 The following regulatory insufficiencies were cited during the investigations #130838-A, #130844-A, #130845-A, #130860-A and #130874-M.	A 000	See attached POC 3/1/26	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure documentation of elopement attempts for one of three tenants reviewed (Tenant #1). Finding follows: Record review on 11/19/25 revealed an incident report (IR) for Tenant #1 indicated the tenant left the program building without staff knowledge on 11/15/25 at approximately 7:30 p.m. According to the IR, Staff A received a call from a community member stating Tenant #1 was at her house and asked if Tenant #1 lived at the assisted living program (ALP). Staff A notified the program registered nurse (RN). Staff A noted the front door alarm sounded earlier and she went to the door to shut it off. The IR indicated Staff A looked outside at the time but didn't see anyone. The RN	A 150		

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instructed Staff A to go to the community member's house and check on Tenant #1. The IR further indicated Tenant #1 left the ALP building on her scooter and a vehicle backed into her, with 911 called.

Tenant #1's record indicated she was 82 years old with a diagnosis including heart failure, unspecified; Rheumatoid Arthritis; major depressive disorder, single episode, unspecified; other cerebrovascular disease and chronic obstructive pulmonary disease. She used a walker for ambulation inside her apartment and an electric scooter to travel from her apartment to other areas of the building.

Tenant #1's most recent assessments and service plan dated 7/15/25 gave no indication of any concerns with exit seeking behavior or elopement attempts. Minimal cognitive impairment was noted. There was nothing to indicate Tenant #1 could not go outside on her own.

Additional record review revealed no documentation of other exit seeking or elopement incidents in the past year.

During an interview on 11/19/25 at 2:20 p.m. Staff A confirmed she worked on the evening of 11/15/25 when the incident occurred. Staff A and her daughter were the two staff working the shift. Staff A said Tenant #1 was not allowed to go outside on her own. This was common knowledge among the staff. Staff A indicated Tenant #1 had some confusion and talked of leaving/going home. She recalled a time about a year ago when Tenant #1 got out the front door on her scooter, but Staff A and the RN intervened before Tenant #1 got out of the driveway.

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A 150	Continued From page 2 During a follow up interview on 11/20/25 at 2:10 p.m. Staff A recalled an incident in the past couple of months when she, Staff E and the RN were in the front area when Tenant #1 entered the door code and went out the front door on her scooter. The RN followed Tenant #1 and brought her back inside. During an interview on 11/19/25 at 1:40 p.m. Staff B indicated prior to the incident on 11/15/25, staff didn't allow Tenant #1 to go outside on her own. Tenant #1 seemed to have more confusion in recent months. If she talked of leaving, staff redirected her or told her to call her daughter. Tenant #1 asked Staff B in the past to open the door for her so she could go home and Staff B redirected her. During an interview on 11/19/25 at 1:55 p.m. Staff C indicated she didn't allow Tenant #1 to go outside on her own, other than in the enclosed courtyard. Staff C explained Tenant #1 seemed confused at times. Tenant #1 would come to the front area on her scooter, with her jacket, and say she was going somewhere, but staff redirected her. Tenant #1 was more confused when she wasn't wearing her oxygen. During an interview on 11/19/25 at 4:00 p.m. Tenant #4 recalled an incident in the past month when Tenant #1 went out the front door without staff knowledge. She mentioned Tenant #5 was present during the incident. During an interview on 11/19/25 at 4:05 p.m. Tenant #5 recalled an incident approximately two to three weeks prior when Tenant #1 went out the front door on her scooter after a visitor opened the door to enter. Tenant #5 alerted staff, who	A 150		

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went outside to bring Tenant #1 back in. During a follow up interview on 11/20/25 at 9:00 a.m., Tenant #5 clarified the door alarm didn't sound during the incident two to three weeks prior because Tenant #1 went out just after a visitor opened the door to come inside. Tenant #5 saw the incident and he found staff to report to them. He mentioned Tenant #6 was also present. Tenant #5 indicated by the time staff got to Tenant #1 on her scooter, she was on the drive partway between the program building and the hospital next door.

During an interview on 11/20/25 at 9:10 a.m. Tenant #6 recalled an incident in the past few weeks when Tenant #1 went out the front door on her scooter. Tenant #6 sat in the dining room with other tenants. Tenant #1 was on her scooter by the front door, watching the door. Tenant #6 assumed Tenant #1 was waiting for the door to open so she could leave and she mentioned this to Tenant #5, who said he was watching her also. A visitor came in the door and Tenant #1 went out on her scooter as the door was open. Tenant #5 went to alert staff. Tenant #6 indicated Tenant #1 frequently stayed by the front door, waiting for it to open, but she hadn't seen the tenant go out the door before this incident.

During an interview on 11/20/25 at 10:10 a.m. Staff D explained all staff were aware Tenant #1 should not be outside on her own. Tenant #1 sometimes tried to leave to go home when she was confused. Staff D recalled an incident in the past year when she walked past the front door and saw Tenant #1 outside. Staff D went outside and brought her back in. She didn't recall if she notified management staff or wrote an incident report.

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A 150	Continued From page 4 During an interview on 11/20/25 at 10:30 a.m. Staff E indicated Tenant #1 was not allowed to go outside on her own. She recalled about two months ago, Tenant #1 used the door coder to open the front door to go outside. Staff E explained she, Staff A and the RN saw Tenant #1 enter the code and go out the door. The RN and Staff A went right after her to bring her inside. Tenant #1 responded she was going home to see her husband. Staff E also recalled an incident in the past six weeks when Tenant #5 informed her Tenant #1 went outside. Staff E went out and found Tenant #1 with her scooter stuck on the sidewalk in front of the building. Staff E indicated she didn't write an incident report about the incident because she was trained to complete IRs only for tenant falls. During an interview on 11/20/25 at 12:00 p.m. Staff F indicated she worked at the program approximately three months. She explained the RN told her Tenant #1 was not allowed to be outside on her own. There were times when Tenant #1 tried to open the front door by pushing on it, which triggered the alarm. Tenant #1 mentioned she was trying to go home or out with her family or (deceased) husband. Staff F said some days Tenant #1 seemed fine cognitively, but other days she was confused or delusional. Tenant #1 once told Staff F someone was trying to break in so she would get the shotgun. During an interview on 11/19/25 at 3:30 p.m. the RN indicated there were prior incidents when Tenant #1 pushed the push bar on the front exit door and triggered the alarm. The RN explained prior to the incident on 11/15/25, staff were trained/told Tenant #1 should not be outside on her own, other than the enclosed courtyard. Tenant #1 tried to exit the front door	A 150		

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A 150	Continued From page 5 approximately every couple of weeks prior to the incident on 11/15/25. During a follow up interview on 11/20/25 at 9:25 a.m. the RN indicated no knowledge of another elopement incident in the past month when a tenant notified staff of Tenant #1 going out the front door. When told staff recalled other elopement incidents when the staff and the RN brought Tenant #1 back inside, the RN had no memory of this. The RN said she didn't know of any incidents when Tenant #1 left the building on her own prior to the incident on 11/15/25. The RN confirmed staff should have documented all elopement incidents on incident reports. She was not aware of any IRs related to elopements for Tenant #1 in the past year, other than the recent incident on 11/15/25.	A 150		
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.	A 145		

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A 145	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to adequately assess tenants' status and needs for 1 of 3 tenants reviewed (Tenant #1). Finding follows: Record review on 11/19/25 revealed an incident report (IR) for Tenant #1 indicated the tenant left the program building without staff knowledge on 11/15/25 at approximately 7:30 p.m. According to the IR, Staff A received a call from a community member stating Tenant #1 was at her house and asking if Tenant #1 lived at the assisted living program (ALP). Staff A notified the program registered nurse (RN). Staff A noted the front door alarm sounded earlier and she went to the door to shut it off. The IR indicated Staff A looked outside at the time but didn't see anyone. The RN instructed Staff A to go to the community member's house and check on Tenant #1. The IR further indicated Tenant #1 left the ALP building on her scooter and a vehicle backed into her, with 911 called. A nursing progress note dated 11/16/25 indicated Staff A received a call from a community member on the evening of 11/15/25 at approximately 7:40 a.m. regarding Tenant #1's presence near the community member's home. Staff A then searched the program building and was unable to locate Tenant #1. The community member called back with an address and Staff A went to the home. The progress note indicated a vehicle backing out of a driveway bumped into Tenant #1 on her scooter. Emergency services were on site when Staff A arrived on scene. Tenant #1 had no visible injuries, but was transported to the emergency room (ER) for further evaluation.	A 145		

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A 145	Continued From page 7 Tenant #1's record indicated she was 82 years old with a diagnosis including heart failure, unspecified; rheumatoid arthritis; major depressive disorder, single episode, unspecified; other cerebrovascular disease and chronic obstructive pulmonary disease. She used a walker for ambulation inside her apartment and an electric scooter to travel from her apartment to other areas of the building. Tenant #1's most recent assessment dated 7/15/25 indicated little to no cognitive impairment or problems with memory, but noted Tenant #1 occasionally hallucinated, which were likely related to a Urinary Tract Infection (UTI). The assessment also instructed staff to make sure Tenant #1 had her oxygen on if she appeared to be confused. The assessment indicated Tenant #1 was able to make consistent, reasonable and organized decisions. Tenant #1's Elopement Risk section of the assessment indicated no history of elopement or wandering off the unit, did not exit seek or verbalize a desire to leave the facility, did not experience periods of altered perception and her mental function did not vary over the course of the day. The elopement section indicated Tenant #1 had a diagnosis of Alzheimer's/dementia, but this information was not located elsewhere in her record. The assessment gave no indication Tenant #1 should not be outside on her own or whether she should have access to the exit door code. The 90 day nursing assessment dated 10/13/25 noted Tenant #1 was alert and oriented x 3, but was forgetful. Additional record review revealed no documentation of other exit seeking or elopement incidents.	A 145		

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A 145	Continued From page 8 Review of surveillance video of the inside of the front door revealed Tenant #1 was on her scooter by the front door on 11/15/25 at 7:24 p.m. She stood up and entered a code on the panel by the door. She pushed the front door open and pushed her scooter through the front door (automatic door opener was reportedly not working at the time of the incident). As Tenant #1 struggled to push her scooter through the door, the alarm eventually sounded because the door was kept open for over 15-20 seconds. Tenant #1 pushed the scooter through the inner front door, then pushed the automatic door opener for the outer front door. She got on her scooter and exited through the outer front door. Staff A arrived at the front door within one minute of the alarm sounding. She turned off the alarm at the code panel. Staff A glanced out the front door window and left the area. The front exit door had a delayed egress alarm system. If the code was not entered prior to attempting to open the door, there was a 15 second delay, with an alarm sounding. The alarm continued to sound until the code was reset at the panel. During an interview on 11/19/25 at 2:20 p.m. Staff A confirmed she worked on the evening of 11/15/25 when the incident occurred. Staff A and her daughter were the two staff working the shift. Staff A passed medications and her daughter assisted tenants with whirlpool baths. Staff A said she thought Tenant #1 was getting a whirlpool bath when she heard the front door alarm sound around 7:30 p.m. Staff A went to the front door to turn off and reset the alarm. She didn't look outside. Staff A assumed a visitor held the door open too long, which could trigger the alarm. Approximately 15-20 minutes later, a woman called the program and said one of the tenants	A 145		

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was hit by a car, but was not specific about the location. Staff A called the registered nurse (RN) to notify her. The community woman called back and gave Staff A a specific location, which she went to. Tenant 1 was lying on the ground at the end of a driveway. Staff A asked Tenant #1 what she was doing and she said she was going home. The emergency personnel indicated they saw no injuries but took Tenant #1 to ER for evaluation. Staff A said Tenant #1 was not allowed to go outside on her own. This was common knowledge among the staff. Staff A stated Tenant #1 had some confusion and talked of leaving/going home. She recalled a time about a year ago when Tenant #1 got out the front door on her scooter, but Staff A and the RN intervened before Tenant #1 got out of the driveway.

During a follow up interview on 11/20/25 at 2:10 p.m. Staff A stated she recalled an incident in the past couple of months when she, Staff E and the RN were in the front area when Tenant #1 entered the door code and went out the front door on her scooter. The RN followed Tenant #1 and brought her back inside.

During an interview on 11/19/25 at 1:40 p.m. Staff B indicated even prior to the incident on 11/15/25, staff didn't allow Tenant #1 to go outside on her own. Tenant #1 seemed to have more confusion in recent months. If she talked of leaving, staff redirected her or told her to call her daughter. Staff B stated she didn't think Tenant #1 knew the code to open the front door. Tenant #1 asked Staff B in the past to open the door for her so she could go home and Staff B redirected her. Tenant #1 was allowed to be in the enclosed courtyard at the rear of the building on her own.

During an interview on 11/19/25 at 1:55 p.m. Staff

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C said she didn't allow Tenant #1 to go outside on her own, other than in the enclosed courtyard. Staff C explained Tenant #1 seemed confused at times. Tenant #1 would come to the front area on her scooter, with her jacket, and say she was going somewhere, but staff redirected her. Tenant #1 was more confused when she wasn't wearing her oxygen.

During an interview on 11/19/25 at 4:00 p.m. Tenant #4 recalled an incident in the past month when Tenant #1 went out the front door without staff knowledge. She said Tenant #5 was present during the incident.

During an interview on 11/19/25 at 4:05 p.m. Tenant #5 recalled an incident approximately two to three weeks prior when Tenant #1 went out the front door on her scooter after a visitor opened the door to enter. Tenant #5 alerted staff, who went outside to bring Tenant #1 back in. During a follow up interview on 11/20/25 at 9:00 a.m., Tenant #5 clarified the door alarm didn't sound during the incident two to three weeks prior because Tenant #1 went out just after a visitor opened the door to come inside. Tenant #5 saw the incident and he found staff to report to them. He said Tenant #6 was also present. Tenant #5 said by the time staff got to Tenant #1 on her scooter, she was on the drive partway between the program building and the hospital next door.

During an interview on 11/20/25 at 9:10 a.m. Tenant #6 recalled an incident in the past few weeks when Tenant #1 went out the front door on her scooter. Tenant #6 sat in the dining room with other tenants. Tenant #1 was on her scooter by the front door, watching the door. Tenant #6 assumed Tenant #1 was waiting for the door to open so she could leave and she mentioned this

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to Tenant #5, who said he was watching her also. A visitor came in the door and Tenant #1 went out on her scooter as the door was open. Tenant #5 went to alert staff. Tenant #6 indicated Tenant #1 frequently stayed by the front door, waiting for it to open, but she hadn't seen the tenant go out the door before this incident.

During an interview on 11/20/25 at 10:30 a.m. Staff E explained Tenant #1 was not allowed to go outside on her own. Tenant #1 used the door code about two months prior to open the front door to go outside. Staff E said she, Staff A and the RN saw Tenant #1 enter the code and go out the door. The RN and Staff A went right after her to bring her inside. Tenant #1 said she was going home to see her husband. Staff E also recalled an incident in the past six weeks when Tenant #5 informed her Tenant #1 went outside. Staff E said she went out and found Tenant #1 with her scooter stuck on the sidewalk in front of the building.

During an interview on 11/20/25 at 12:00 p.m. Staff F said she had worked at the program approximately three months. She explained the RN told her Tenant #1 was not allowed to be outside on her own. There were times when Tenant #1 tried to open the front door by pushing on it, which triggered the alarm. Tenant #1 said she was trying to go home or out with her family or (deceased) husband. Staff F mentioned some days Tenant #1 seemed fine cognitively, but other days she was confused or delusional. Tenant #1 once told Staff F someone was trying to break in so she would get the shotgun.

During an interview on 11/19/25 at 3:30 p.m. the RN stated there were prior incidents when Tenant #1 pushed the push bar on the front exit door and

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triggered the alarm. The RN observed the video of the incident on 11/15/25 and saw Tenant #1 entered the code to open the door. She didn't realize Tenant #1 knew the door code. The door alarm eventually did sound because it was kept open for over 15 seconds as Tenant #1 struggled to get her scooter through the door. The video showed Staff A responded, but she turned the alarm off without checking outside. The RN said prior to the incident on 11/15/25, staff were trained/told Tenant #1 should not be outside on her own, other than the enclosed courtyard. The RN explained prior cognitive testing showed only mild impairment. Tenant #1's forgetfulness came and went. Tenant #1 might have more confusion when her oxygen wasn't on. Tenant #1 could seem very focused and on track, but then make a comment about her deceased husband, as if he was still living. When Tenant #1 tried to go out the front door in the past, she said she was going home. When asked if Tenant #1's current assessments and service plan indicated concerns with exit seeking, confusion and past elopement attempts, the RN replied she didn't know because she didn't do the most recent assessments, which were completed in July. She indicated a corporate regional nurse did the assessments. The RN said Tenant #1 tried to exit the front door approximately every couple of weeks prior to the incident on 11/15/25. She confirmed this should have been included in Tenant #1's current assessments and service plan.

During a follow up interview on 11/20/25 at 9:25 a.m. the RN indicated she had no knowledge of another elopement incident in the past month when a tenant notified staff of Tenant #1 going out the front door. When told staff recalled other elopement incidents when the staff and the RN brought Tenant #1 back inside, the RN had no

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A 145	Continued From page 13 memory of this. The RN said she didn't know of any incidents when Tenant #1 left the building on her own prior to the incident on 11/15/25. The RN verified the information in Tenant #1's assessment which indicated she didn't try to exit seek or talk of wanting to leave was incorrect. The RN stated she didn't complete or review the most recent assessments.	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 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 develop and implement service plans to meet tenant needs for 1 of 3 tenants reviewed (Tenant #1). Finding follows: Record review on 11/19/25 revealed an incident report (IR) for Tenant #1 indicated the tenant left the program building without staff knowledge on 11/15/25 at approximately 7:30 p.m. According to the IR, Staff A received a call from a community member stating Tenant #1 was at her house and asking if Tenant #1 lived at the assisted living program (ALP). Staff A notified the program	A 350		

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registered nurse (RN). Staff A noted the front door alarm sounded earlier and she went to the door to shut it off. The IR indicated Staff A looked outside at the time but didn't see anyone. The RN instructed Staff A to go to the community member's house and check on Tenant #1. The IR further indicated Tenant #1 left the ALP building on her scooter and a vehicle backed into her, with 911 called.

A nursing progress note dated 11/16/25 indicated Staff A received a call from a community member on the evening of 11/15/25 at approximately 7:40 a.m. regarding Tenant #1's presence near the community member's home. Staff A then searched the program building and was unable to locate Tenant #1. The community member called back with an address and Staff A went to the home. The progress note indicated a vehicle backing out of a driveway bumped into Tenant #1 on her scooter. Emergency services were on site when Staff A arrived on scene. Tenant #1 had no visible injuries, but was transported to the emergency room (ER) for further evaluation.

Tenant #1's record indicated she was 82 years old with a diagnosis including heart failure, unspecified; rheumatoid arthritis; major depressive disorder, single episode, unspecified; other cerebrovascular disease and chronic obstructive pulmonary disease. She used a walker for ambulation inside her apartment and an electric scooter to travel from her apartment to other areas of the building.

Tenant #1's most recent service plan dated 7/15/25 provided very little information regarding Tenant #1's cognitive status other than to note she occasionally hallucinated, which were determined to be a prelude to a Urinary Tract

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Infection (UTI). The service plan indicated Tenant #1 could use her scooter as she chose to get to/from her room. The family arranged for transportation to appointments. There was no information regarding exit seeking or elopement attempts. The service plan gave no indication Tenant #1 should not be outside on her own or whether she should have access to the exit door code.

Additional record review revealed no documentation of other exit seeking or elopement incidents.

Review of surveillance video of the inside of the front door revealed Tenant #1 was on her scooter by the front door on 11/15/25 at 7:24 p.m. She stood up and entered a code on the panel by the door. She pushed the front door open and pushed her scooter through the front door (automatic door opener was reportedly not working at the time of the incident). As Tenant #1 struggled to push her scooter through the door, the alarm eventually sounded because the door was kept open for over 15-20 seconds. Tenant #1 pushed the scooter through the inner front door, then pushed the automatic door opener for the outer front door. She got on her scooter and exited through the outer front door. Staff A arrived at the front door within one minute of the alarm sounding. She turned off the alarm at the code panel. Staff A glanced out the front door window and left the area. The front exit door had a delayed egress alarm system. If the code was not entered prior to attempting to open the door, there was a 15 second delay, with an alarm sounding. The alarm continued to sound until the code was reset at the panel.

During an interview on 11/19/25 at 2:20 p.m. Staff

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A confirmed she worked on the evening of 11/15/25 when the incident occurred. Staff A and her daughter were the two staff working the shift. Staff A passed medications and her daughter assisted tenants with whirlpool baths. Staff A thought Tenant #1 was getting a whirlpool bath when she heard the front door alarm sound around 7:30 p.m. Staff A went to the front door to turn off and reset the alarm. She didn't look outside. Staff A assumed a visitor held the door open too long, which could trigger the alarm. Approximately 15-20 minutes later, a woman called the program and said one of the tenants was hit by a car, but was not specific about the location. Staff A called the registered nurse (RN) to notify her. The community woman called back and gave Staff A a specific location, which she went to. Tenant 1 was lying on the ground at the end of a driveway. Staff A asked Tenant #1 what she was doing and she said she was going home. The emergency personnel indicated they saw no injuries but took Tenant #1 to ER for evaluation. Staff A said Tenant #1 was not allowed to go outside on her own. This was common knowledge among the staff. Staff A stated Tenant #1 had some confusion and talked of leaving/going home. She recalled a time about a year ago when Tenant #1 got out the front door on her scooter, but Staff A and the RN intervened before Tenant #1 got out of the driveway.

During a follow up interview on 11/20/25 at 2:10 p.m. Staff A stated she recalled an incident in the past couple of months when she, Staff E and the RN were in the front area when Tenant #1 entered the door code and went out the front door on her scooter. The RN followed Tenant #1 and brought her back inside.

During an interview on 11/19/25 at 1:40 p.m. Staff

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B explained even prior to the incident on 11/15/25, staff didn't allow Tenant #1 to go outside on her own. Tenant #1 seemed to have more confusion in recent months. If she talked of leaving, staff redirected her or told her to call her daughter. Staff B stated she didn't think Tenant #1 knew the code to open the front door. Tenant #1 asked Staff B in the past to open the door for her so she could go home and Staff B redirected her. Tenant #1 was allowed to be in the enclosed courtyard at the rear of the building on her own.

During an interview on 11/19/25 at 1:55 p.m. Staff C said she didn't allow Tenant #1 to go outside on her own, other than in the enclosed courtyard. Staff C explained Tenant #1 seemed confused at times. Tenant #1 would come to the front area on her scooter, with her jacket, and say she was going somewhere, but staff redirected her. Tenant #1 was more confused when she wasn't wearing her oxygen.

During an interview on 11/19/25 at 4:00 p.m. Tenant #4 recalled an incident in the past month when Tenant #1 went out the front door without staff knowledge. She said Tenant #5 was present during the incident.

During an interview on 11/19/25 at 4:05 p.m. Tenant #5 recalled an incident approximately two to three weeks prior when Tenant #1 went out the front door on her scooter after a visitor opened the door to enter. Tenant #5 alerted staff, who went outside to bring Tenant #1 back in. During a follow up interview on 11/20/25 at 9:00 a.m., Tenant #5 clarified the door alarm didn't sound during the incident two to three weeks prior because Tenant #1 went out just after a visitor opened the door to come inside. Tenant #5 saw the incident and he found staff to report to them.

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He said Tenant #6 was also present. Tenant #5 mentioned by the time staff got to Tenant #1 on her scooter, she was on the drive partway between the program building and the hospital next door.

During an interview on 11/20/25 at 9:10 a.m. Tenant #6 recalled an incident in the past few weeks when Tenant #1 went out the front door on her scooter. Tenant #6 sat in the dining room with other tenants. Tenant #1 was on her scooter by the front door, watching the door. Tenant #6 assumed Tenant #1 was waiting for the door to open so she could leave and she mentioned this to Tenant #5, who said he was watching her also. A visitor came in the door and Tenant #1 went out on her scooter as the door was open. Tenant #5 went to alert staff. Tenant #6 indicated Tenant #1 frequently stayed by the front door, waiting for it to open, but she hadn't seen the tenant go out the door before this incident.

During an interview on 11/20/25 at 10:30 a.m. Staff E explained Tenant #1 was not allowed to go outside on her own. Tenant #1 used the door code about two months prior to open the front door to go outside. Staff E said she, Staff A and the RN saw Tenant #1 enter the code and go out the door. The RN and Staff A went right after her to bring her inside. Tenant #1 said she was going home to see her husband. Staff E also recalled an incident in the past six weeks when Tenant #5 informed her Tenant #1 went outside. Staff E said she went out and found Tenant #1 with her scooter stuck on the sidewalk in front of the building.

During an interview on 11/20/25 at 12:00 p.m. Staff F said she had worked at the program approximately three months. She explained the

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RN told her Tenant #1 was not allowed to be outside on her own. There were times when Tenant #1 tried to open the front door by pushing on it, which triggered the alarm. Tenant #1 said she was trying to go home or out with her family or (deceased) husband. Staff F mentioned some days Tenant #1 seemed fine cognitively, but other days she was confused or delusional. Tenant #1 once told Staff F someone was trying to break in so she would get the shotgun.

During an interview on 11/19/25 at 3:30 p.m. the RN stated there were prior incidents when Tenant #1 pushed the push bar on the front exit door and triggered the alarm. The RN observed the video of the incident on 11/15/25 and saw Tenant #1 entered the code to open the door. She didn't realize Tenant #1 knew the door code. The door alarm eventually did sound because it was kept open for over 15 seconds as Tenant #1 struggled to get her scooter through the door. The video showed Staff A responded, but she turned the alarm off without checking outside. The RN indicated prior to the incident on 11/15/25, staff were trained/told Tenant #1 should not be outside on her own, other than the enclosed courtyard. The RN explained prior cognitive testing showed only mild impairment. Tenant #1's forgetfulness came and went. Tenant #1 might have more confusion when her oxygen wasn't on. Tenant #1 could seem very focused and on track, but then make a comment about her deceased husband, as if he was still living. When Tenant #1 tried to go out the front door in the past, she said she was going home. When asked if Tenant #1's current assessments and service plan indicated concerns with exit seeking, confusion and past elopement attempts, the RN replied she didn't know because she didn't do the most recent assessments, which were completed in July. She

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A 350	Continued From page 20 indicated a corporate regional nurse did the assessments. The RN said Tenant #1 tried to exit the front door approximately every couple of weeks prior to the incident on 11/15/15. She confirmed this should have been included in Tenant #1's current assessments and service plan. During a follow up interview on 11/20/25 at 9:25 a.m. the RN indicated she had no knowledge of another elopement incident in the past month when a tenant notified staff of Tenant #1 going out the front door. When told a staff person recalled other elopement incidents when the staff and the RN brought Tenant #1 back inside, the RN had no memory of this. The RN said she didn't know of any incidents when Tenant #1 left the building on her own prior to the incident on 11/15/25. The RN verified the information in Tenant #1's assessment which indicated she didn't try to exit seek or talk of wanting to leave was incorrect. During an interview on 11/20/25 at 9:45 a.m. the Regional Vice President confirmed Tenant #1's history of exit seeking and prior elopement attempts should have been addressed in her current service plan.	A 350		

Plan of correction for Homestead of Chariton

Complaint investigation date: 11/19/2025-11/25/2025

A150 481-67.2(3) Program policies and procedures

67.2(3) The program shall follow the policies and procedures established by the program.

1. RN no longer employed with Homestead of Chariton, and the new program nurse has been trained on incident reporting, including elopements, elopement attempts and responding to door alarms.
2. All program staff shall receive training on incident reporting to include elopements, elopement attempts, and responding to door alarms upon hire and no less than annually.
3. Employee files to be audited by director or designee periodically, but no less than annually to determine compliance.
4. Date of completion: March 1st, 2026

A145 481-69.22(3) Evaluation of Tenant

69.22(3) Evaluation annually and with significant change.

1. Tenant #1 has had a significant change evaluation completed.
2. The evaluation of all tenants will be done annually and with significant change. The program will evaluate each tenant's functional, cognitive and health status.
3. Tenant files will be audited periodically, by the director or designee to determine compliance with evaluation of tenant criteria.
4. Date of compliance: March 1, 2026

A350 481-69.26(1) Service Plans

69.26(1) A Service plan shall be developed for each tenant based on the evaluations conducted.

1. Tenant #1 has had a service plan update to reflect their current needs based on accurate evaluation.
2. Service plans will be completed for all tenants to reflect current needs on or before admission and updated with changes as needed.

3. Tenant files will be audited periodically by the director or designee to determine compliance with service plans.
4. Date of compliance: March 1, 2026