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
	S0313	A. BUILDING: _____ B. WING _____	C 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF OSCEOLA MEMORY CARE	334 NORTH WEST VIEW DRIVE OSCEOLA, IA 50213

(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: 0 Tenants with cognitive impairment: 11 Total census: 11 The following regulatory insufficiencies were cited during the investigation of Incident #130708-I and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000	see attached POC 5/27/26	
A 200	481-67.9(4)f Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4)?Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall include the following: f. Services will be provided to tenants in accordance with the training provided. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program staff failed to follow the delegation training provided by the Program nurse when caring for 1 of 3 tenants reviewed (Tenant #C1). Finding follows: Record review on 4/13/26 revealed Tenant #C1 admitted to the Program on 10/14/24 had diagnoses which included (but not limited to)	A 200		

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A 200	Continued From page 1	A 200		

heart failure, atrial fibrillation, essential (primary) hypertension, and a family history of osteoporosis. A diagnosis listed as history of falling was added with an onset date of 6/2/25. A service plan dated 8/11/25 noted Tenant #C1 received hospice services as of 3/25/25 with a hospice admitting diagnosis of Congestive Heart Failure. The plan directed the following assistance for Tenant #C1:

-Mobility: She required one staff for mobility. She used a two wheel walker when she ambulated. Staff were to use a gait belt for safety. Tenant #C1 may use a wheelchair for long distances or indicates she was too weak to walk.

-Transfers: She required one staff assist with transfers. Staff were instructed to use a gait belt for safety. She used a wheeled walker. Tenant #C1 may use a wheelchair for long distances or indicates she was too weak to walk.

-Bathroom Assistance: Tenant #C1 needed one staff assist with toileting.

The Program self-reported an incident involving Tenant #C1 which occurred on 10/15/25. An incident report dated 10/15/25 noted Tenant #C1 fell while being assisted in the bathroom by Staff A and noted "Staff report that they were assisting (Tenant #C1) in the bathroom at the time of the occurrence. Staff report they had assisted (Tenant #C1) from her wheelchair to the toilet. Staff got (Tenant #C1's) walker for her to use after using the restroom to walk back to her recliner. (Tenant #C1) stood up from using the restroom, staff assisted with pericare and pulling her pants up, staff went to move her wheelchair out of the way for her to walk by with her walker and when doing so, (Tenant #C1) fell. Staff

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A 200	Continued From page 2	A 200		

reported that (Tenant #C1) fell backwards into the bathroom sink vanity then fell to the floor on her left side. Staff were not using a gait belt." Immediate action taken by the program included vitals, a head injury log initiated, and range of motion completed. The incident report further noted "Tenant #C1 reported some soreness to her left upper leg. Tenant #C1 was assisted up using a gait belt and staff assistance x2. Tenant #C1 used her walker to ambulate approximately five feet to her wheelchair. Tenant #C1 reported soreness to her left leg and was bearing some weight, but not full weight. Nurse contacted hospice. Hospice recommended (Tenant #C1) be seen in the ER due to the sensitivity of her left leg upon hospice's assessment. 911 was called and (Tenant #C1) was transferred via ambulance to the CCH ER to be evaluated. Disciplinary action record completed and reviewed with staff regarding not using a gait belt."

A progress note dated 10/15/25 confirmed the above incident report entry. A second progress note dated 10/15/25 noted an update from the emergency room and identified Tenant #C1 suffered a fractured sacrum and two fracture areas within her pelvis and was being admitted for pain control. A progress note dated 10/17/25 noted an update from the hospital and noted Tenant #C1 was being transferred to the Kavanagh Hospice House. Tenant #C1 never returned to the program.

Staff A was no longer employed by the program and thus was unavailable for an interview, however, review of Staff A's disciplinary action form dated 10/15/25 noted the Work Rule Violated as "Not following service plan" and the Summary of Violation as "Staff did not utilize a gait belt when assisting resident with toileting and

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A 200	Continued From page 3 the resident fell." Staff A was provided re-education by the program. A review of Staff A's "Universal Worker Skills Checklist" delegation training form dated 7/29/25 revealed Staff A had received delegation training which included "Ambulation/Transfers/Gait Belt" and "Fall Prevention and Procedure." During an interview on 4/13/26 at 1:15 p.m., the Executive Director (ED) confirmed Staff A failed to use a gait belt during the incident with Tenant #C1, Tenant C1's service plan instructed the staff on the assistance Tenant #C1 required, and Staff A received delegation training on the expectations. During an interview on 4/13/26 at 2:55 p.m., the LPN Resident Care Coordinator (RCC) confirmed Staff A failed to use a gait belt during the incident with Tenant #C1, Tenant #C1's service plan instructed the staff on the assistance Tenant #C1 required, and Staff A received delegation training on the expectations. The RCC stated the expectation for Staff A would have been for Staff A to use a gait belt and retain a hold on the gait belt while Staff A turned to move the wheelchair out of the way. On 4/13/26 at 3:40 p.m., the ED and RCC confirmed the above findings.	A 200		

Plan of Correction for Homestead of Osceola Memory Care

Survey Completion Date: 4/13/26

A200 481-67.9 (4)f Staffing

67.9(4)f Nurse delegation procedures. Services will be provided to tenants in accordance with the training provided.

1. Tenant # C1 has since been discharged from the program.
2. All staff will be adequately trained and delegated by the program's nurse to ensure that all staff providing cares are competent to meet the individual needs of the tenants within their first 30 days of hire date and then not less than annually.
3. Employee files are to audited by director or designee periodically but no less than annually to determine compliance with nurse delegation procedures
4. Date of compliance: May 27, 2026