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
	S0333	A. BUILDING: _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF ALBIA	6592 165TH STREET ALBIA, IA 52531

(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. Number of tenants without cognitive disorder: 17 Number of tenants with cognitive disorder: 3 TOTAL census of Assisted Living Program: 20 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program as well as the investigation into Complaints #111855-C, #114021-C and #114217-C	A 000	See Attached POC 3/4/24	
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 follow the policy on sexual relationships between residents with cognitive impairment affecting 1 of 5 discharged tenants (Tenant C5). Findings include: 1) Record review on 10/31/23 of annual evaluations revealed Tenant C5 was administered the Mini Mental Questionnaire on 4/7/23. Tenant C5 had 9 errors on the questionnaire indicating her intellectual functioning was severely impacted. A Functional Assessment completed on the same date identified Tenant C5 had difficulty recalling recent events, had difficulty with her long-term memory and had difficulty with	A 150		

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

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A 150	Continued From page 1	A 150		

decision-making. The program did not complete a Global Deterioration Scale to assess Tenant C5's cognitive functioning.

On 11/1/23 at 11:20 AM Staff A recalled she would find Tenant C5 and another tenant together in the same bed. The other tenant did not have issues with dementia. Tenant C5 would frantically approach Staff A and ask her to get the other tenant out of her room. There were many nights Tenant C5 would say the other tenant grabbed her or tried to choke her. Tenant C5 was very confused and Staff A did not believe the other tenant actually harmed Tenant C5. Staff A documented these incidents in the communication log whenever Tenant C5 had a bad night and would verbally pass on the information to the next shift.

On 11/1/23 at 12:05 PM Staff B stated he witnessed four different men Tenant C5's bed. He did not witness any sexual activity, but the tenants were naked. There would be times Tenant C5 would ask Staff B to get a male tenant out of her room. Nothing physically harmful happened to Tenant C5 but there were times she believed something might happen. Tenant C5 said she didn't feel safe. Staff B made these incidents known by recording the information in the old communication book. He also let the next staff coming in to work know what happened.

On 10/31/23 at 4:15 PM Staff C reported she found Tenant C5 in bed twice with a former tenant in her apartment. Tenant C5 did not seem upset at the time. Both times Tenant C5 and her partner were naked. There were times Tenant C5 would come up to the front desk and make comments such as, that man is hurting me. Staff C did not ever see marks on Tenant C5's body

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A 150	Continued From page 2 indicating another tenant harmed her. Tenant C5 said things like that man hurt me and then behave very affectionately toward the same man. Others ignored Tenant C5's comments because of her level of cognition. The program had a policy on sexual relationships between residents with cognitive impairment. A policy statement identified the program would protect individuals with cognitive impairment who were unable to consent to sexual relationships. Cognitive impairment for the purpose of the policy would be considered those residents with a Global Deterioration score of 5 or above. If staff suspected or observed sexual relations between tenants where at lease one tenant had cognitive impairment, there were to notify the nurse on call immediately. The tenant's physician was to determine if the tenant had capacity to consent. The physician's decision regarding capacity to consent was to be kept in the tenant's clinical record. The power of attorney would be notified of the physician's decision. The service plan was to be updated to reflect interventions to reduce the risks of such an encounter. On 11/1/23 at 9:20 AM the Administrator reported she was aware Tenant C5 was in a sexual relationship with one tenant but not others. The Administrator was aware of the policy on sexual relationships between tenants. Tenant C5's cognitive impairment was marked as severe, which would mean a GDS of 5 or over, according to the Administrator. She confirmed the policy was not followed.	A 150		
A 155	481-67.3(1) Tenant Rights	A 155		

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A 155	Continued From page 3 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure its employees treated of 6 of 9 current tenants reviewed with respect (Tenants #1, #4, #6, #7, #8 and #9). Findings include: On 11/1/23 at 12:25 PM, Tenant #9 stated Staff D came in to assist her when she had a yeast infection. Staff D told Tenant #9 to lay on her bed in order for Staff D to apply nystatin powder. Staff D reportedly told Tenant #9 she had big boobs. . Staff D rubbed the nystatin powder in places the tenant did not have redness. The first time Staff D worked an overnight shift, Tenant #9 went out the door and saw Staff D sleeping. On 10/30/23 at 3:30 PM, Tenant #1 recalled Staff D came to her apartment and saw Tenant #1's hydrocodone on the table. Tenant #1 asked Staff D if she wanted one pill and Staff D said yes. Staff D reportedly took the medication and gave it to a co-worker to put in the drug buster for disposal. Staff D told Tenant #1 she couldn't have any more hydrocodone which is why she took the hydrocodone. One night Tenant #1 asked Staff D to do her laundry and the staff said she could not do it because she was the only one who worked.	A 155		

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A 155	Continued From page 4 On 10/30/23 at 4:40 PM, Tenant #6 reported he only experienced problems with Staff D. Staff D said things to him in a rude manner such as lift up your feet or you can do it yourself. Tenant #6 was aware he had trouble lifting up his feet at times due to him freezing up because he has Parkinson's. On 10/31/23 at 3:50 PM, Tenant #7 stated she was to receive eye drops. Tenant #7 kept the eye drops in her room and staff were to watch her take them. This wasn't a problem with anyone except for Staff D. Staff D refused to let Tenant #7 administer her own eye drops and instead administered the eye drops herself. On 10/31/23 at 4:05 PM, Tenant #8 reported she only had issues with Staff E. Tenant #8 experienced bowel incontinence. Staff D stated Tenant #8 should be able to clean herself up and did not need assistance. All staff help Tenant #8 with peri-care except with the exception of Staff E. Staff E handed Tenant #8 her brief and wipes and left Tenant #8 on the toilet. On 11/2/23 at 12:15 PM Tenant #4 said she was left in the whirlpool tub by an unknown staff member for what seemed to be a long period of time. Tenant #4 paged for assistance but did not receive it. Tenant #4 said she was cold and a bit scared. On 11/1/23 at 12:25 PM, Tenant #9 stated Staff D came in to assist her when she had a yeast infection. Staff D told Tenant #9 to lay on her bed in order for Staff D to apply nystatin powder. Staff D reportedly told Tenant #9 she had big boobs. . Staff D rubbed the nystatin powder in places the tenant did not have redness. The first time Staff	A 155		

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A 155	Continued From page 5 D worked an overnight shift, Tenant #9 went out the door and saw Staff D sleeping. The Administrator confirmed the findings on 11/2/23 at 1:15 PM.	A 155		
A 415	481-67.19(3)c Record Checks 67.19(3)c If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete a criminal background check for 1 of 6 staff reviewed (Staff A). Findings follow: Record review of personnel files on 10/30/23 revealed Staff A was hired on 1/11/22. The program completed the Single Contact License and Background Check (SING) for Staff A on 12/17/21. The results of the background check noted further research was required into Staff A's criminal history. The program did not complete the background check prior to hiring Staff A. The Administrator confirmed these findings on 10/31/23 at 8:15 AM.	A 415		

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A 145	Continued From page 6	A 145		
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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to evaluate 1 of 5 current tenants (Tenant #2) reviewed when she developed a wound on her foot. Findings include: Record review of office/clinic notes on 10/31/23 revealed Tenant #2 visited the Advanced Registered Nurse Practitioner on 9/1/23 for treatment of wounds to her right foot, medial ankle, posterior heel and medial heel. Tenant #2 had a history of a right great toe amputation secondary to infection. Tenant #2 was diagnosed with type 2 diabetes, venous insufficiency without prior ablation and significant peripheral neuropathy in the right foot and ankle. Tenant #2's service plan, dated 9/1/23, was updated to identify she had wound treatments managed by home health.	A 145		

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A 145	Continued From page 7 A review of Tenant #2's evaluations revealed the program did not complete a full evaluation of Tenant #2's health, cognitive and functional needs when she developed wounds to her foot on 9/1/23. The Administrator confirmed this finding on 11/2/23 at 1:15 PM.	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 update the service plan of 1 of 5 discharged tenants (Tenant C5) when changes were needed. Findings include: 1) Record review on 10/31/23 of annual evaluations revealed Tenant C5 was administered the Mini Mental Questionnaire on 4/7/23. Tenant C5 had 9 errors on the questionnaire indicating her intellectual functioning was severely impacted. A Functional Assessment completed on the same date identified Tenant C5 had difficulty recalling recent events, had difficulty with her long-term memory and had difficulty with	A 350		

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A 350	Continued From page 8	A 350		

decision-making.

On 11/1/23 at 11:20 AM Staff A recalled she would find Tenant C5 and another tenant together in the same bed. The other tenant did not have issues with dementia. Tenant C5 would frantically approach Staff A and ask her to get the other tenant out of her room. There were many nights Tenant C5 would say the other tenant grabbed her or tried to choke her. Tenant C5 was very confused and Staff A did not believe the other tenant actually harmed Tenant C5. Staff A documented these incidents in the communication log whenever Tenant C5 had a bad night and would verbally pass on the information to the next shift.

On 11/1/23 at 12:05 PM Staff B stated he witnessed four different men Tenant C5's bed. He did not witness any sexual activity, but the tenants were naked. There would be times Tenant C5 would ask Staff B to get a male tenant out of her room. Nothing physically harmful happened to Tenant C5 but there were times she believed something might happen. Tenant C5 said she didn't feel safe. Staff B made these incidents known by recording the information in the old communication book. He also let the next staff coming in to work know what happened.

On 10/31/23 at 4:15 PM Staff C reported she found Tenant C5 in bed twice with a former tenant in her apartment. Tenant C5 did not seem upset at the time. Both times Tenant C5 and her partner were naked. There were times Tenant C5 would come up to the front desk and make comments such as, that man is hurting me. Staff C did not ever see marks on Tenant C5's body indicating another tenant harmed her. Tenant C5 said things like that man hurt me and then

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A 350	Continued From page 9 behave very affectionately toward the same man. Others ignored Tenant C5's comments because of her level of cognition. A review of Tenant C5's service plan, written on 4/7/23, did not identify how staff should intervene when Tenant C5 became upset with a male partner and believed he was trying to harm her. The Administrator confirmed these findings on 11/1/23 at 9:20 AM.	A 350		

Homestead of Albia Plan of correction

3/4/24

A-415 Record checks

Background checks on employees will be completed prior to employment, including extended background check if needed. Extended background check on Staff A has now been completed and in her file. Completed 11/6/23

A-145 Evaluation of tenant

Will complete full evaluation on tenants with annual review and significant changes. Nurse retraining completed 11/3/23

A-155 Tenant rights

Staff education on tenant rights. Staff D terminated 11/6/23

A-150 Program policy and procedure

Program policy and procedures will be followed, staff education. Completed 11/3/23

A-350 Service plans

Service plans will be reviewed and updated as needed with evaluations/significant changes. Tenants interventions will be on service plan. Nurse education completed 11/3/23