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
	S0335	A. BUILDING: _____ B. WING _____	C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF ALGONA	512 N FINN DRIVE ALGONA, IA 50511

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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 impairment: 25 Number of tenants with cognitive impairment: 9 Total census: 34 The following regulatory insufficiencies were cited the investigation of Complaint #115337-C and Complaint #118423-C and the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	A 000		
A 325	481-67.9(1) Staffing 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to provide sufficient staff to meet the needs of the tenants. This pertained to the all tenants in the memory care (census of nine tenants). Findings follow: 1. Review of the ALP Monitoring Entrance Form reflected a census of 34 tenants. Nine tenants had a Global Deterioration Scale (GDS) of 4 or greater. The building had a general population section and memory care section (all certified as an ALP/D). The staffing pattern as reflected on	A 325	The Plan of Correction is attached	

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the ALP Monitoring Entrance Form indicated there was one staff in the general population and one in the memory care unit on all shifts. The form also reflected two tenants received hospice services (Tenant #1 and Tenant #2). The memory care unit had 9 tenants and the general population had 25 tenants.

Continued record review revealed the schedule provided from 4/14/24 to 4/27/24 reflected on 4/14/24, 4/18/24, 4/20/24, 4/21/24, 4/22/24, 4/24/24 and 4/27/24 there was not a float staff scheduled on first shift and two staff were scheduled for the building. On 4/24/24 there were two staff scheduled, including Staff F. Management staff reported Staff F walked out that morning (4/24/24). On 4/25/24 three staff were scheduled; however, Staff F was one of those staff that was scheduled to work.

2. When observed on 4/24/24 at 11:10 a.m. in the memory care unit there was one staff assigned. Staff C had come in as Staff F had walked out that morning. Staff A was assigned to the general population. Staff C served the lunch meal. Tenant #1 required assistance with feeding and was assisted initially by a family member and then by Staff K.

When observed on 4/24/24 at approximatley 12:15 p.m. Tenant #4 was observed repeatedly asking about her car and the need to locate her purse. At times she ambulated without her walker and staff provided reminders that she needed to use it.

When observed on 4/24/24 at approximatley 12:25 p.m. Staff A and Staff K transferred Tenant #2 from his wheelchair into his recliner. Staff A and Staff K went under each arm and he pivot

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transferred with his walker into the recliner.

When observed on 4/24/24 at 4:30 p.m. Staff E removed the crust off of a grilled sandwich, cut it up and placed the bites of sandwich in the soup. Staff E fed Tenant #1 her meal and prompted her to swallow her food during the meal. There was a float staff that was in the memory care unit at that time.

When observed on 4/25/24 at the lunch meal Tenant #1 had shredded/ground meat with sauce on it and blended corn. Staff D assisted her with eating. She provided prompts for Tenant #1 to chew and swallow. Staff A was assigned to the memory care unit and Staff D was assigned to the general population. There was no float staff observed.

3. When interviewed on 4/24/24 at 10:08 a.m. Staff A said Tenant #2 took two people for transfers. He was weight bearing and would take a few steps. She said he had required the assistance of two staff for a few weeks.

When interviewed on 4/24/24 at 12:14 p.m. Staff C said Tenant #2 took two staff for transfer 100% of the time. This had been occurring for the past few weeks.

When interviewed on 4/25/24 at 12:20 p.m. Staff D said Tenant #2 took two staff for transfers.

When interviewed on 4/29/24 at 3:15 p.m. the Resource Nurse said she had not observed a transfer with Tenant #2 recently but was told he was requiring one to two people for transfer.

Record review on 4/25/24 and 4/29/24 of Tenant #2's file revealed A Request for Waiver of

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Administrative Rule was completed for rules including a routine two person assist with transfers. The care needs and functionality indicated Tenant #2 required the assistance of two staff including for transfers.

4. When interviewed on 4/24/24 at 12:14 p.m. Staff C said at times on the weekends there was not a float staff. She said two times per week there was not a float on her shift. It was her first priority to focus on cares. Bed changes and sometimes laundry did not get done. She said Tenant #2 took two peopleto transfer and Tenant #1 took time to work with. She said there were also tenants who displayed behaviors on second shift.

When interviewed on 4/25/24 at 12:20 p.m. Staff D said there was quite often not a float staff on duty. With one staff in the general population and one staff in the memory care unit, it was not sufficient staffing. She said Tenant #1 had to wait awhile at meals as she needed assistance with feeding. More recently Tenant #2 also required assistance with eating. She said Tenant #3 also took two staff for showers due to her behaviors. Staff D said she got everything done but she stayed past her shift to do so. She said it took 20 to 30 minutes for staff to assist Tenant #2 with bathing.

When interviewed on 4/30/24 at 8:36 a.m. the Resident Care Coordinator said housekeeping and activity staff were helping when they did not have a float. Regarding Tenant #2, the float or staff from the general population came back to assist with transfers. She said Staff K assisted with feeding lunch.

When interviewed on 4/29/24 at 3:15 p.m. the

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Resource Nurse said they tried to have a float staff five times per week. She said regarding cares, Tenant #1 required a one to one assist and staff did most of her cares.

When interviewed on 4/30/24 at approximatley 9:10 a.m. the Executive Director said there was one staff in memory care and one staff in the general population on each shift. There was also a float from 7 a.m. to 11:00 a.m. and 4:00 p.m. to 8:00 p.m. except on weekends. She said regarding feeding assistance with Tenant #1, usually Staff K assisted (department staff not on weekends). She said it took 30 minutes to assist her with feeding. She was going to speak with corporate staff about staffing. She said families had brought up wanting two staff in memory care.

When interviewed on 4/29/24 at 4:05 p.m. a family member said he/she was concerned a tenant was not being bathed due to not observing a clothing change for the tenant in four days.

5. Record review on Documentation Task Survey Reports from February to April 2024 for Tenants #1, #2, #3, #4 and #5 (all memory care tenants) reflected scheduled cares and tasks not documented as completed including: bladder documentation, bowel documentation, removal of soiled clothes from the apartment, visual checks, prompts for toileting, emptying of a catheter bag, behavior monitoring and provision of a snack.

Continued review revealed Resident Meeting notes dated 2/6/24 reflected a concern that beds were not being stripped each week or made daily.

6. In summary, there was not sufficient staff to meet the needs of tenants in memory care with two staff on duty for the entire building on first and

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A 325	Continued From page 5 second shifts. Memory care had nine tenants and Tenant #1 and Tenant #2 were on hospice. Tenant #1 required assistance with all of her cares and required feeding assistance at meals. It was estimated to take 30 minutes to assist her at meals. Tenant #2 required the assistance of two staff to transfer and at times required assistance with eating. It required two staff to bathe Tenant #3 due to behaviors. Staff indicated laundry or bed changes did not get done, staff stayed late to ensure cares were completed, and time providing a shower could be 20 to 30 minutes regarding supervision of the unit. A family member voiced a concern regarding bathing not being completed due to the tenant wearing the same clothes for four days. The task records reflected scheduled cares/tasks not documented for all tenants reviewed who resided in the memory care unit. The Executive Director indicated families had wanted two staff in the memory care unit.	A 325		
A 345	481-67.9(4)b 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, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse delegation training within 30 days of employment for 5 of 6	A 345		

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staff reviewed regarding delegations (Staff E, G, H, I, J.) Findings include:

1. Review of Staff J's training documents on 4/23/24 revealed a hire date of 1/10/24. Staff J had not received nurse delegation training at the time of the review.

2. Review of Staff I's training documents on 4/23/24 revealed a hire date of 11/15/23. Staff I had nurse delegation training completed on 11/17/23 and 2/9/24. The training did not include training on anti-coagulant medication or hypoglycemia and hyperglycemia.

3. Review of Staff H's training documents on 4/23/24 revealed a hire date of 2/16/24. Staff H had nurse delegation training documented on 3/7/24. The training did not include training on anti-coagulant medication or hypoglycemia and hyperglycemia.

4. Review of Staff E's training documents on 4/23/24 revealed a hire date of 2/12/24. Staff E had nurse delegation training on 3/7/24. The training did not include training on anti-coagulant medication or hypoglycemia and hyperglycemia.

5. Review of Staff G's training documents on 4/23/24 revealed a hire date of 10/6/23. Staff G did not have nurse delegation training completed with his employment at the program in 2023. Staff G did not have current nurse delegation training including training on anti-coagulant medication or hypoglycemia and hyperglycemia.

6. When interviewed on 4/30/24 at approximately 9:10 a.m. the Executive Director confirmed all nurse delegation training was provided and there were tenants who received anticoagulant

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A 345	Continued From page 7 medication and were diabetic.	A 345		
A 400	481-67.19(3) Record Checks 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete a background check prior to employment. This pertained to 1 of 5 current staff reviewed (Staff G). Findings follow: 1. Review of Staff G's training documents on 4/23/24 revealed a hire date of 10/6/23. A Single Contact License & Background Check document dated 10/6/23 revealed no records were found in the Abuse Registries and further research was required for the Criminal History Background Check. On 10/11/23 it was returned with no record found. Continued record review revealed Staff G was hired on 10/6/23 and first worked on 10/14/23. 2. When interviewed on 4/30/24 at approximately 9:10 a.m. the Executive Director confirmed all background checks were provided for the staff reviewed.	A 400		
A 145	481-69.22(3) Evaluation of Tenant	A 145		

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A 145	Continued From page 8 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 observation, interview and record review the Program failed to complete evaluations as needed. This pertained to 4 of 6 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Review of Tenant #1's file on 4/25/24 and 4/29/24 revealed Progress Notes indicating the following: - On 1/22/24 staff reported Tenant #1 pocketed her food, especially meats. An order was received to shred or finely chop any meats. - On 1/23/24 Tenant #1 lost her balance, hit the wall and had a closed head injury to the back of her head. She went to the emergency department (ED) and returned with no new orders. - On 3/5/24 staff reported Tenant #1 had an open area on her coccyx. It measured 1.6 x 0.3 x 0.2 centimeters (cm). The area the cleansed and	A 145		

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vitamin A & D ointment was applied.
- On 3/20/24 staff reported Tenant #1 slipped off the toilet at 1:00 a.m. on 3/19/24.
- On 4/12/24 Tenant #1 agreed to be admitted to hospice.
- On 4/15/24 it was noted Tenant #1 continued to pocket food and coughed on food/drinks. Her weight was down and an order was sent to the primary care provider (PCP) regarding her admission to hospice.
- On 4/22/24 a significant change assessment was completed due to her admission to hospice on 4/16/24, weight loss and decline. It was noted Tenant #1 was on a regular diet, however, due to pocketing of food, she needed fine or chopped meats.
- On 4/22/24 (late entry) the hospice nurse wrote a note for kitchen staff to use moist ground meat for Tenant #1 per verbal order. The hospice nurse would send over the signed order.
- On 4/25/24 Tenant #1 had a cushion for her wheelchair provided by hospice to prevent a pressure injury.
- On 4/26/24 Tenant #1 was ambulating out of the bathroom and tipped sideways and hit a shelf in the bathroom. Staff was able to keep her from falling.

Continued record review revealed Tenant #1's weight in February 2023 was 169.2 and her weight in April 2024 was 120 (49.2 pound weight loss). Tenant #1 weighed 129.2 pounds in March and in April weighed 120 pounds (9.2 pound weight loss).

An Assisted Living Wound Assessments indicated on 3/5/24 Tenant #1 had a pressure wound, stage II on her sacrum. It measured 1.6 x 0.3 x 0.2 cm. On 3/26/24 it was noted the area was healed at that time.

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When observed on 4/24/24 at approximately 11:10 a.m. and 4:36 p.m. and 4/25/24 at the lunch meal, Tenant #1 had staff or family sit beside her and feed her the meal with verbal prompts to chew and swallow. Tenant #1 was seated in a wheelchair when observed.

The record revealed an annual evaluation was completed on 1/2/24 and 1/3/24 and then again with significant change on 4/22/24. Evaluations were not completed as needed with weight loss, falls, diet orders, use of a wheelchair, a stage II wound and treatment or prior to being admitted to hospice. An evaluation was completed on 4/22/24; however, it was not timely related to the issues notes above and did not reflect the new diet order. Evaluations were not completed as needed.

2. Review of Tenant #2's file on 4/25/24 and 4/29/24 revealed Progress Notes indicating the following:
- On 1/30/24 it was noted a a urinanalysis (UA) was completed on 1/26/24 and showed a small amount of blood. An order was received for Ciprofloxacin 500 milligrams (mg), twice daily for 10 days.
- On 2/16/24 Tenant #2 tested positive for COVID-19 on 2/15/24 and he appeared short of breath. Vitals were taken and his oxygen saturation was 69%. Tenant #2 was transported to the hospital via emergency transport and was admitted due to acute renal failure.
- On 2/19/24 it was noted Tenant #2 had trouble urinating in the hospital and a scan revealed a large amount of urine in the bladder. He was treated for a urinary tract infection (UTI). Tenant #2 was discharged from the hospital on 2/19/24.
- On 2/22/24 Tenant #2 was sent to the ED as

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the private duty nurse was unable to perform a straight cath due to swollen prostate. A Foley cath was placed. It was to be removed Monday at the ED and his ability to void independently would be assessed.

- On 3/4/24 (late entry) a change of condition evaluation was completed related to Tenant #2's admission to hospice and weight loss. The hospice nurse would change the catheter once per month.
- On 4/5/24 the hospice aide was assisting him with his shower and he stood up and became angry. He left the shower, grabbed onto the hospice aide's arms and would not let go. Staff went in and assisted. Tenant #2 would not get dressed and would not take his medications. Eventually he allowed staff to put a t-shirt and pants on.
- On 4/12/24 Tenant #2 spent more time in the morning in bed asleep. Hospice brought in a hospital bed. He was becoming hard to transfer and ambulate. Two staff were assisting with transfers as needed.
- On 4/16/24 it was noted Tenant #2 had a good day. He required a pivot transfer with two staff and walker most of the time.
- On 4/16/24 a hospital bed and bedside commode delivered.

A review of weights revealed Tenant #2's weight in January 2024 was 211.4 pounds and was 188.0 pounds in April (23.4 pound weight loss).

When observed on 4/24/24 at approximately 12:25 p.m. Staff A and Staff K transferred Tenant #2 from his wheelchair into his recliner. Staff A and Staff K went under each arm and he pivot transferred with his walker into the recliner.

When interviewed on 4/24/24 at 10:08 a.m. Staff

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A 145	Continued From page 12 A said Tenant #2 took two people for transfers. He was weight bearing and would take a few steps. She said he had required the assistance of two staff for a few weeks. When interviewed on 4/24/24 at 12:14 p.m. Staff C said Tenant #2 took two staff for transfer 100% of the time. This had started a couple of weeks prior. When interviewed on 4/25/24 at 12:20 p.m. Staff D said Tenant #2 took two staff for transfers. When interviewed on 4/29/24 at 3:15 p.m. the Resource Nurse said she had not observed a transfer with Tenant #2 recently but was told he was requiring one to two people for transfer. Located in the tenant's file was a completed Request for Waiver of Administrative Rule form for rules including a routine two person assist with transfers. The care needs and functionality indicated Tenant #2 required the assistance of two staff including for transfers. It was dated 4/22/24 but was not submitted to the Department until 4/29/24 (second week of the onsite). Further record review revealed evaluations were completed on 8/17/23 and on 3/4/24. Evaluations were not completed with Tenant #2's weight loss, assistance of two staff for transfers, behaviors, catheter placement, urinary tract infections, or use of a hospital bed and bedside commode. 3. Review of Tenant #3's file on 4/29/24 revealed Progress Notes indicating the following: - On 2/12/24 staff reported on 2/11/24 Tenant #3 threw her belongings, went into other tenants' apartments and yelled at staff and her family that visited. It was unusual behavior for her.	A 145		

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A 145	Continued From page 13 - On 3/13/24 staff were able to get Tenant #3 to take a shower after multiple missed showers due to refusals. Staff reported it took two staff to complete the shower and "for the duration of the shower ...was physically and verbally (sic) with staff." Staff attempted to reassure her and direct her without success. She kicked one staff in knee and scratched another staff. - On 4/16/24 Tenant #3 urinated in the garbage can, hit staff and staff found feces in her apartment. - On 4/18/24 a bruise was noted to Tenant #3's right upper arm with unknown etiology. The bruise was 8 centimeters (cm) by 7 cm. - On 4/26/24 the nurse was called to the memory care unit due to Tenant #3 refusing to take her medications. She was able to get Tenant #3 to take her medications. When interviewed on 4/30/24 at approximately 9:10 a.m. the Executive Director reported during a shower Tenant #3 bit Staff J. It did not break the skin but left a bruise. She confirmed in an email sent on 4/30/24, the two staff that provided the shower when the incident occurred were Staff D and Staff K. It occurred on 3/13/24. A review of the tenant's weights revealed Tenant #3 weighed 123.2 pounds on 1/9/24 and weighed 116.7 pounds on 4/3/24 (6.5 pound weight loss). From 2/3/24 to 2/29/24 she lost 5.4 pounds or -4.4%. Further record review revealed Documentation Survey Reports from February 2024 to April 2024 reflected behavior observation task. The behaviors noted for Tenant #3 included repetitive or obsessive behaviors, physical aggression, undressing in public, refusal of cares and dressing inappropriately.	A 145		

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When observed on 4/24/24 at approximately 11:10 a.m. Staff C attempted to administer Tenant #3's medications. She refused and Staff C placed the medications in a dessert and Tenant #3 took them.

When interviewed on 4/24/24 at 10:08 a.m. Staff A said Tenant #3 was quite aggressive. It was difficult to administer her medications as she did not understand and became irritated. She bit one of the staff who was attempting to give her a shower.

The tenant's most recent evaluation was dated 2/9/24 (30 day evaluations). Evaluations were not completed as needed with significant change including behaviors, weight loss, bruising of unknown etiology and refusal of cares.

4. Record review on 4/29/24 of Tenant #4's file revealed Progress Notes indicating the following:
- On 12/17/23 it was noted that on 12/23/23 staff contacted the nurse at 10:30 p.m. regarding behaviors. Tenant #4 yelled at staff, followed them around, went into other tenants' apartments. When the nurse arrived, she observed Tenant #4 in another tenant's apartment yelling at him. The tenant was very upset people were coming into her house at night. The nurse spent 1.5 hours with Tenant #4 to calm her down.
- On 1/22/24 an order was received to start Seroquel 25 milligram (mg), one tablet every evening. A task was added to monitor behaviors every shift.
- On 2/7/24 staff reported on 2/6/24 that Tenant #4 had behaviors including following staff around, yelling, going into other tenants' apartments and hitting staff.
- On 2/9/24 an order was received to increase

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A 145	Continued From page 15 Seroquel to 50 mg daily. - On 4/25/24 it was noted a nurse was called by staff the night prior due to behaviors. Tenant #4 was verbally abusive and used profanity towards staff. She also displayed physical behaviors towards staff. She rammed her walker into staff's shins. - On 4/29/24 an order was received to increase Seroquel to 100 mg every evening. Continued record review revealed Documentation Survey Reports from February 2024 to April 2024 reflected behavior observation task. The behaviors noted for Tenant #4 included repetitive or obsessive behaviors, refusal of cares, suspicious or paranoid behaviors. When observed on 4/24/24 at approximately 12:15 p.m. Tenant #4 was observed and repeatedly asked about her car and need to locate her purse. At times she ambulated without her walker and staff provided reminders that she needed to use it. The tenant's most recent evaluations were dated 9/10/23 (30 day). Evaluations were not completed as needed regarding Tenant #4's behaviors and new medication orders. 5. When interviewed on 4/30/24 at approximately 9:10 a.m. the Executive Director confirmed all evaluations were provided for the tenants reviewed.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include:	A 290		

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A 290	Continued From page 16 i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 6 of 6 tenants reviewed (Tenants #1, #2, #3, #4, #5 and #6). Findings follow: 1. Review of Tenant #1's file on 4/25/24 and 4/29/24 revealed Progress Notes indicating the following: - On 2/13/24 Tenant #1 was tested for COVID-19 and was positive. Her legal representative and primary care provider (PCP) were notified. She was asymptomatic at that time. - On 2/14/24 a correction was made to to the 2/13/24 note, Tenant #1 had experienced vomiting and diarrhea. On 2/14/24 she was asymptomatic. - On 3/5/24 staff alerted the nurse to an open area on Tenant #1's coccyx. The area was cleansed and A & D ointment was applied. The PCP and legal representative were made aware. - On 4/1/24 (90 day review) it was noted Tenant #1 tested positive on 2/14/24 for COVID-19, recovered and had no side effects. The pressure sore on her coccyx was healed and she had a cushion to help with the pressure relief. Continued record review revealed 90 day nurse review in nurse's notes mentioned the prior	A 290		

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issues of Tenant #1 being COVID-19 positive and a healed open area; however, nurse's notes were not documented by exception when Tenant #1 recovered from COVID-19 and was no longer in isolation precautions or when the open area on her coccyx healed.

2. Review of Tenant #2's file on 4/25/24 and 4/29/24 revealed Progress Notes indicating the following:
- On 1/30/24 it was noted a urinanalysis (UA) was completed on 1/26/24 and showed a small amount of blood. An order was received for Ciprofloxacin 500 milligrams (mg), twice daily for 10 days.
- On 2/10/24 staff reported Tenant #2 had a fever of 103 degrees. He was tested for COVID-19 and was negative. Staff was instructed to give acetaminophen and have him rest. The nurse called back to check on him and his temperature was 97.9 degrees and he slept most of the day.
- On 2/16/24 it was noted Tenant #2 tested positive for COVID-19 on 2/15/24 and he appeared short of breath. Vitals were taken and his oxygen saturation was 69%. Tenant #2 was transported to the hospital via emergency transport and was admitted due to acute renal failure.
- On 2/19/24 it was noted Tenant #2 had trouble urinating in the hospital and a scan revealed a large amount of urine in the bladder. He was treated for a urinary tract infection (UTI). Tenant #2 was discharged from the hospital on 2/19/24.
- On 2/22/24 Tenant #2 was sent to the ED as the private duty nurse was unable to perform a straight cath due to swollen prostate. A Foley cath was placed. It was to be removed Monday at the ED and his ability to void independently would be assessed.

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A 290	Continued From page 18 Continued record review revealed nurse's notes were not documented by exception related to the completion of the antibiotic ordered on 1/30/24 related to blood in his urine. Nurse's notes were also not completed to follow up on Tenant #2's COVID-19 positive status and to follow up on the placement of Foley cath and scheduled removal the following Monday. 3. Review of Tenant #3's file on 4/29/24 revealed Progress Notes indicating the f following: - On 2/13/24 Tenant #3 tested positive for COVID-19. She had an elevated temperature of 99.8 degrees. Her legal representative and PCP were notified. - On 2/14/24 it was noted Tenant #3 said she felt fine and was just tired. Continued record review revealed nurse's notes were not documented by exception related to Tenant #3 positive COVID-19 status, when it was resolved and when isolation precautions ended. 4. Review of Tenant #4's file on 4/29/24 revealed a Progress Note dated 2/19/24 indicating Tenant #4 tested positive for COVID-19 on 2/18/24. She sounded slightly congested. Continued record review revealed nurse's notes were not documented to follow up after Tenant #4 tested positive for COVID-19, regarding when it resolved and when isolation precautions ended. 5. Review of Tenant #5's on 4/29/24 file revealed a Progress Note dated 2/19/24 indicating Tenant #5 tested positive for COVID-19 on 2/16/24. Continued record review revealed nurse's notes were not documented to follow up after Tenant #5	A 290		

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A 290	Continued From page 19 tested positive for COVID-19, regarding when it resolved and when isolation precautions ended. 6. Review of Tenant #6's file on 4/29/24 revealed a Progress Note dated 2/19/24 indicating Tenant #6 tested positive for COVID-19 on 2/17/24. She reported being tired and had productive cough. Continued record review revealed nurse's notes were not documented to follow up after Tenant #6 tested positive for COVID-19, regarding when it resolved and when isolation precautions ended. 7. When interviewed on 4/30/24 at approximatley 9:10 a.m. the Executive Director confirmed all nurse's notes for the tenants reviewed were provided.	A 290		
A 320	481-69.25(1)o Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record) This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete incident reports as required. This pertained to 2 of 6 tenants reviewed (Tenant #3 and Tenant #4). Findings follow:	A 320		

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1. Review of Tenant #3's file on 4/29/24 revealed Progress Notes indicating the following:
- On 2/12/24 staff reported on 2/11/24 Tenant #3 threw her belongings, went into other tenants' apartments and yelled at staff and her family that visited. It was unusual behavior for her.
- On 3/13/24 staff were able to get Tenant #3 to take a shower after multiple missed showers due to refusals. Staff reported it took two staff to complete the shower and "for the duration of the shower ...was physically and verbally (sic) with staff." Staff attempted to reassure her and direct her without success. She kicked one staff in knee and scratched another staff.
- On 4/16/24 Tenant #3 urinated in the garbage can, hit staff and staff found feces in her apartment.
- On 4/18/24 a bruise was noted to Tenant #3's right upper arm with unknown etiology. The bruise was 8 centimeters (cm) by 7 cm.

When interviewed on 4/30/24 at approximately 9:10 a.m. the Executive Director reported during a shower Tenant #3 bit a staff person. It did not break the skin but left a bruise. She confirmed in an email sent on 4/30/24, the two staff that provided the shower when the incident occurred were Staff D and Staff K. It occurred on 3/13/24.

When interviewed on 4/29/24 at 3:15 p.m. the Resource Nurse confirmed Tenant #3 bit Staff K and an incident report was not completed.

No reports related to the incidents noted above could be located.

2. Review of Tenant #4's file on 4/29/24 revealed Progress Notes indicating the following:
- On 12/27/23 it was noted that on 12/23/23 staff contacted the nurse at 10:30 p.m. regarding

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A 320	Continued From page 21 behaviors. Tenant #4 yelled at staff, followed them around, went into other tenants' apartments. When the nurse arrived, she observed Tenant #4 in another tenant's apartment yelling at him. The tenant was very upset people were coming into her house at night. The nurse spent 1.5 hours with Tenant #4 to calm her down. - On 2/7/24 staff reported on 2/6/24 that Tenant #4 had behaviors including following staff around, yelling, going into other tenants' apartments and hitting staff. - On 4/25/24 it was noted a nurse was called by staff the night prior due to behaviors. Tenant #4 was verbally abusive and used profanity towards staff. She also displayed physical behaviors towards staff. She rammed her walker into staff's shins. A Staff Communication Report dated 4/24/24 indicated there was a change in Tenant #4's behavior and she was aggressive, agitated and cried. No incident reports related to the behaviors noted above could be located. 3. When interviewed on 4/30/24 at approximately 9:10 a.m. the Executive Director confirmed all incident reports and medication error reports were provided.	A 320		
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	A 350		

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A 350	Continued From page 22 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 updated service plans as needed. This pertained to 5 of 6 tenants reviewed (Tenants #1, #2, #3, #4 and #5). Findings follow: 1. Review of Tenant #1's file on 4/25/24 and 4/29/24 revealed Progress Notes indicating the following: - On 1/22/24 staff reported Tenant #1 pocketed her food, especially meats. An order was received to shred or finely chop any meats. - On 1/23/24 Tenant #1 lost her balance, hit the wall and had a closed head injury to the back of her head. She went to the emergency department (ED) and returned with no new orders. - On 3/5/24 staff reported Tenant #1 had an open area on her coccyx. It measured 1.6 x 0.3 x 0.2 centimeters (cm). The area the cleansed and vitamin A & D ointment was applied. - On 3/20/24 staff reported Tenant #1 slipped off the toilet at 1:00 a.m. on 3/19/24. - On 4/12/24 Tenant #1 agreed to be admitted to hospice. - On 4/15/24 it was noted Tenant #1 continued to pocket food and coughed on food/drinks. Her weight was down and an order was sent to the primary care provider (PCP) regarding her admission to hospice. - On 4/22/24 a significant change assessment was completed due to her admission to hospice	A 350		

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on 4/16/24, weight loss and decline. It was noted Tenant #1 was on a regular diet, however, due to pocketing of food, she needed fine or chopped meats.
- On 4/22/24 (late entry) the hospice nurse wrote a note for kitchen staff to use moist ground meat for Tenant #1 per verbal order. The hospice nurse would send over the signed order.
- On 4/25/24 Tenant #1 had a cushion for her wheelchair provided by hospice to prevent a pressure injury.
- On 4/26/24 Tenant #1 was ambulating out of the bathroom and tipped sideways and hit a shelf in the bathroom. Staff was able to keep her from falling.

Continued record review revealed Tenant #1's weight in February 2023 was 169.2 and her weight in April 2024 was 120 (49.2 pound weight loss). Tenant #1 weighed 129.2 pounds in March and in April weighed 120 pounds (9.2 pound weight loss).

An Assisted Living Wound Assessment indicated on 3/5/24 Tenant #1 had a pressure wound, stage II on her sacrum. It measured 1.6 x 0.3 x 0.2 cm. On 3/26/24 it was noted the area was healed at that time.

When observed on 4/24/24 at approximately 11:10 a.m. and 4:36 p.m. and on 4/25/24 at the lunch meal, Tenant #1 had staff or family sit beside her and feed her the meal with verbal prompts to chew and swallow. Tenant #1 was seated in a wheelchair when observed.

Continued record review revealed the service plans were updated annually on 1/16/24 and 1/3/24 and then with significant change on 4/22/24. The service plan was not updated as

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needed with weight loss, falls, diet orders, use of a wheelchair, a stage II wound and treatment and when she was admitted to hospice. The service plan was updated on 4/22/24; however, it was not timely related to the issues notes above and did not reflect the new diet order. The service plan was not updated as needed and failed to reflect the service needs of Tenant #1.

2. Review of Tenant #2's file on 4/25/24 and 4/29/24 revealed Progress Notes indicating the following:
- On 1/30/24 it was noted a a urinanalysis (UA) was completed on 1/26/24 and showed a small amount of blood. An order was received for Ciprofloxacin 500 milligrams (mg), twice daily for 10 days.
- On 2/16/24 Tenant #2 tested positive for COVID-19 on 2/15/24 and he appeared short of breath. Vitals were taken and his oxygen saturation was %. Tenant #2 was transported to the hospital via emergency transport and was admitted due to acute renal failure.
- On 2/19/24 it was noted Tenant #2 had trouble urinating in the hospital and a scan revealed a large amount of urine in the bladder. He was treated for a urinary tract infection (UTI). Tenant #2 was discharged from the hospital on 2/19/24.
- On 2/22/24 Tenant #2 was sent to the ED as the private duty nurse was unable to perform a straight cath due to swollen prostate. A Foley cath was placed. It was to be removed Monday at the ED and his ability to void independently would be assessed.
- On 4/5/24 the hospice aide was assisting him with his shower and he stood up and became angry. He left the shower, grabbed onto the hospice aide's arms and would not let go. Staff went in and assisted. Tenant #2 would not get dressed and would not take his medications.

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Eventually he allowed staff to put a t-shirt and pants on.
- On 4/12/24 Tenant #2 spent more time in the morning in bed asleep. Hospice brought in a hospital bed. He was becoming hard to transfer and ambulate. Two staff were assisting with transfers as needed.
- On 4/16/24 it was noted Tenant #2 had a good day. He required a pivot transfer with two staff and walker most of the time.
- On 4/16/24 a hospital bed and bedside commode delivered.

A review of weights revealed Tenant #2's weight in January 2024 was 211.4 pounds and was 188.0 pounds in April (23.4 pound weight loss).

When observed on 4/24/24 at approximately 12:25 p.m. Staff A and Staff K transferred Tenant #2 from his wheelchair into his recliner. Staff A and Staff K went under each arm and he pivot transferred with his walker into the recliner.

When interviewed on 4/24/24 at 10:08 a.m. Staff A said Tenant #2 took two people for transfers. He was weight bearing and would take a few steps. She said he had required the assistance of two staff for a few weeks.

When interviewed on 4/24/24 at 12:14 p.m. Staff C said Tenant #2 took two staff for transfer 100% of the time. This had started a couple of weeks prior.

When interviewed on 4/25/24 at 12:20 p.m. Staff D said Tenant #2 took two staff for transfers.

When interviewed on 4/29/24 at 3:15 p.m. the Resource Nurse said she had not observed a transfer with Tenant #2 recently but was told he

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A 350	Continued From page 26 was requiring one to two people for transfer. Located in the tenant's file was a completed Request for Waiver of Administrative Rule form for rules including a routine two person assist with transfers. The care needs and functionality indicated Tenant #2 required the assistance of two staff including for transfers. It was dated 4/22/24 but was not submitted to the Department until 4/29/24 (second week of the onsite). Further record review revealed service plans were dated 8/17/23 and 3/4/24. The service plan was not updated as needed and did not reflect Tenant #2's weight loss, assistance of two staff for transfers, behaviors, catheter placement, urinary tract infections, or use of a hospital bed and bedside commode. 3. Review of Tenant #3's file on 4/29/24 revealed Progress Notes indicating the following: - On 2/12/24 staff reported on 2/11/24 Tenant #3 threw her belongings, went into other tenants' apartments and yelled at staff and her family that visited. It was unusual behavior for her. - On 3/13/24 staff were able to get Tenant #3 to take a shower after multiple missed showers due to refusals. Staff reported it took two staff to complete the shower and "for the duration of the shower ...was physically and verbally (sic) with staff." Staff attempted to reassure her and direct her without success. She kicked one staff in knee and scratched another staff. - On 4/16/24 Tenant #3 urinated in the garbage can, hit staff and staff found feces in her apartment. - On 4/26/24 the nurse was called to the memory care unit due to Tenant #3 refusing to take her medications. She was able to get Tenant #3 to take her medications.	A 350		

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A 350	Continued From page 27 When interviewed on 4/30/24 at approximately 9:10 a.m. the Executive Director reported during a shower Tenant #3 bit Staff J. It did not break the skin but left a bruise. She confirmed in an email sent on 4/30/24, the two staff that provided the shower when the incident occurred were Staff D and Staff K. It occurred on 3/13/24. A review of the tenant's weights revealed Tenant #3 weighed 123.2 pounds on 1/9/24 and weighed 116.7 pounds on 4/3/24 (6.5 pound weight loss). From 2/3/24 to 2/29/24 she lost 5.4 pounds or -4.4%. Further record review revealed Documentation Survey Reports from February 2024 to April 2024 reflected behavior observation task. The behaviors noted for Tenant #3 included repetitive or obsessive behaviors, physical aggression, undressing in public, refusal of cares and dressing inappropriately. When observed on 4/24/24 at approximately 11:10 a.m. Staff C attempted to administer Tenant #3's medications. She refused and Staff C placed the medications in a dessert and Tenant #3 took them. When interviewed on 4/24/24 at 10:08 a.m. Staff A said Tenant #3 was quite aggressive. It was difficult to administer her medications as she did not understand and became irritated. She bit one of the staff who was attempting to give her a shower. Continued record review revealed the most recent service plan was dated 2/9/24 (30 day service plan). The service plan was not updated as needed and did not reflect the service needs	A 350		

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A 350	Continued From page 28 of Tenant #3 including behaviors and interventions, weight loss and refusal of cares. 4. Record review on 4/29/24 of Tenant #4's file revealed Progress Notes indicating the following: - On 12/27/23 it was noted that on 12/23/23 staff contacted the nurse at 10:30 p.m. regarding behaviors. Tenant #4 yelled at staff, followed them around, went into other tenants' apartments. When the nurse arrived, she observed Tenant #4 in another tenant's apartment yelling at him. The tenant was very upset people were coming into her house at night. The nurse spent 1.5 hours with Tenant #4 to calm her down. - On 1/22/24 an order was received to start Seroquel 25 milligram (mg), one tablet every evening. A task was added to monitor behaviors every shift. - On 2/7/24 staff reported on 2/6/24 that Tenant #4 had behaviors including following staff around, yelling, going into other tenants' apartments and hitting staff. - On 2/9/24 an order was received to increase Seroquel to 50 mg daily. - On 4/25/24 it was noted a nurse was called by staff the night prior due to behaviors. Tenant #4 was verbally abusive and used profanity towards staff. She also displayed physical behaviors towards staff. She rammed her walker into staff's shins. - On 4/29/24 an order was received to increase Seroquel to 100 mg every evening. Continued record review revealed Documentation Survey Reports from February 2024 to April 2024 reflected behavior observation task. The behaviors noted for Tenant #4 included repetitive or obsessive behaviors, refusal of cares, suspicious or paranoid behaviors.	A 350		

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A 350	Continued From page 29 When observed on 4/24/24 at approximately 12:15 p.m. Tenant #4 was noted repeatedly asking about her car and the need to locate her purse. At times she ambulated without her walker and staff provided reminders that she needed to use it. 5. Review of Tenant #5's file on 4/29/24 revealed Progress Notes indicating the following: - On 3/7/24 staff heard a noise and found Tenant #5 laying on the floor. He had a scrape to the back of his head and a scrape to his left elbow. He went to the ED and returned with orders for an ice pack as needed. - On 4/19/24 it was noted Tenant #5's groin was very red and had a yeast odor. - On 4/19/24 an order was received for lotrisone cream and Nystatin powder. Continued record review revealed Documentation Survey Reports from March and April 2024 reflected bathing refusals, verbal and physical abusive behaviors and care refusals. In April 2024 four bathing entries were charted as either refused or the tenant was not available. The tenant's April 2024 medication administration record (MAR) reflected an order for clotrimazole-betamethasone cream to be applied to the groin topically twice daily for a yeast infection with a start date of 4/20/24. It also reflected an order for Nystatin Powder to be applied to the groin topically twice daily for a yeast infection. Continued record review revealed the service plan was dated 6/28/23. The service plan was not updated as needed and did not reflect the fall with injury, behaviors and interventions, care refusals and interventions for yeast infection in his groin.	A 350		

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A 350	Continued From page 30 6. When interviewed on 4/30/24 at approximately 9:10 a.m. the Executive Director confirmed all service plans were provided for tenants reviewed.	A 350		
A 430	481-69.27(1)c Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurse reviews as needed with changes in health status. This pertained to 2 of 6 tenants reviewed (Tenant #1 and Tenant #5). Findings follow: 1. Review of Tenant #1's file on 4/25/24 and 4/29/24 revealed a Stop and Watch-Early Warning Tool document dated 1/18/24 indicating Tenant #1 had not had a bowel movement (BM) for eight days. Her stool felt hard and impacted. The nurse report section of the document dated 1/22/24 (four days later) indicated new orders were received for daily stool softener and Dulcolax tablets as needed.	A 430		

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A 430	Continued From page 31 The January 2024 Documentation Survey Report indicated Tenant #1 did not have a BM from 1/12/24 to 1/19/24. The February 2024 Documentation Survey Report indicated Tenant #1 did not have BM from 2/14/24 to 2/19/24. The April 2024 Documentation Survey Report did not reflect a BM from 4/10/24 to 4/14/24. Tenant #1's service plan dated 1/16/24 reflected she was not able to verbalize if she had issues with urination or if she was in pain. The service plan reflected Tenant #1 required staff assistance with toileting. Tenant #1 was staged at a seven on the Global Deterioration Scale, which indicated very severe cognitive decline. Continued record review revealed the January 2024 medication administration record (MAR) reflected an order for Dulcolax Suppository 10 mg, as needed (PRN)for constipation. The order indicated to give if complaints of no BM, and to report to the nurse if there was no stool in 24 hours. The medication was not documented as administered as needed in January 2024. The MAR also reflected an order for Colace capsule 100 mg, twice daily for bowel management. It was ordered on 1/19/24 and was documented as administered. The February 2024 MARs reflected the PRN order for Dulcolax. The medication was documented as administered on 2/21/24 and was charted as effective. The April 2024 MARs reflected the PRN order for Dulcolax. There was no documented use in April. The MAR also reflected an order to discontinue Colace capsule 100 mg on 4/3/24 and to start Docusate Sodium liquid 50 mg/5 milliters (ml), give 15 ml by mouth twice daily.	A 430		

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A 430	Continued From page 32 When interviewed on 4/24/24 at 2:30 p.m. Tenant #1's family member stated she visited in mid-January and was told it had been a couple days since Tenant #1 had a BM. She returned a few days later and learned it had been seven days without a BM. Staff told her the nurse was aware. The next time she was there it had been nine days since Tenant #1 had a BM. Staff reported to her that Tenant #1 had vomited stomach bile. The family member went and got an enema. Tenant #1 had a BM right away, within five minutes. She was plugged with a lot of stool. The family member ended up talking to the nurse about it. When interviewed on 4/25/24 at 12:20 p.m. Staff D stated Tenant #1 had vomited and it looked like stomach bile. She said she believed it had been nine days without a BM for Tenant #1 back in January. Something was said to the Resource Nurse and she told staff to give Miralax and no further direction was provided. Miralax had been administered and was not effective. She said Tenant #1 looked uncomfortable She said Tenant #1's family gave her an enema and if was effective. When interviewed on 4/29/24 at 3:15 p.m. the Resource Nurse said staff had called her as Tenant #1 had not had a BM for a couple of days. She said her stool was digitally removed. She said Tenant #1 was not constipated; it was soft stool but she was not able to push it out. Staff were to report if a tenant does not have a BM in three to four days. Tenant #1 now had liquid Colace. A nurse review was not completed related to nine days without a BM, the report of vomiting, report	A 430		

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A 430	Continued From page 33 of digital removal of stool and administration of an enema. The MARs for January lacked any documented doses of the Dulcolax suppository as needed. Additionally, there were no nurse reviews completed related to the lack of BMs in February or April as noted above. Nurse reviews were not completed related to staff reports and documentation related to lack of BMs and also to provide recommendations related to the change in health status for Tenant #1. 2. Review of Tenant #5's file on 4/30/24 revealed Progress Notes indicating on 4/19/24 it was noted his groin was very red and had a yeast odor. An order was received for lotrisone cream and Nystatin powder. The tenant's April MAR reflected an order for clotrimazole-betamethasone cream as well as Nystatin Powder to be applied to his groin twice daily for a yeast infection. A nurse review was not completed related to the yeast infection in Tenant #5's groin and the topical treatments prescribed. 3. When interviewed on 4/30/24 at approximately 9:10 a.m. the Executive Director confirmed all nurse reviews were provided for the tenants reviewed.	A 430		
A 460	481-69.28(4) Food Service 69.28(4) Therapeutic diets may be provided by a program. If therapeutic diets are provided, they shall be prescribed by a physician, physician assistant, or advanced registered nurse practitioner. A current copy of the Iowa Simplified Diet Manual published by the Iowa Dietetic	A 460		

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A 460	Continued From page 34 Association shall be available and used in the planning and serving of therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and for reviewing procedures for food preparation and service for therapeutic diets. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure a licensed dietician wrote and approved the therapeutic menus as well as reviewed procedures for food preperation and service for therapeutic diets. This pertained to of 1 of 1 tenants reviewed on a therapeutic diet (Tenant #1). Findings follow: 1. When observed on 4/24/24 at 11:10 a.m. Tenant #1 was observed in the memory care dining area with a family member seated beside her. The hot food cart arrived from the main kitchen and Staff C served the food. A plate was provided to Tenant #1 and her family member assisted with feeding her. The plate had breaded chicken tenders, macaroni and cheese and carrots. The meat did not appear whole; however, the consistency was difficult to determine based on the amount of breading on the meat. There was no sauce or gravy observed on the meat when it was served. The family member requested catsup due to dryness of meat and it was provided. The family member sat with her and fed her with verbal prompts to chew her food. Staff K eventually replaced the family member and assisted Tenant #1 with eating. When observed on 4/24/24 at 4:30 p.m. dietary staff brought the hot cart to memory care and she spoke to staff regarding Tenant #1's meal. Dietary	A 460		

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staff reported the nurse told her to tell staff to remove the crust and put the sandwich in the soup. Staff E reported the Resident Care Coordinator told her to not give Tenant #1 salad or the fruit. Staff E removed the crust on the grilled sandwich, cut it up and placed the bites of sandwich in the soup. Staff E fed Tenant #1 her meal and prompted her to swallow her food during the meal.

When observed on 4/25/24 at the lunch meal Tenant #1 had shredded/ground meat with sauce on it and blended corn. Staff D assisted her with eating. She provided prompts for Tenant #1 to chew and swallow.

2. Review of Tenant #1's file on 4/25/24 and 4/29/24 revealed she was admitted to hospice on 4/16/24. She was staged at a seven on the Global Deterioration Scale, which indicated very severe cognitive decline. The service plan indicated Tenant #1 had a communication book with pictures and she attempted to point at pictures to communicate. The service plan dated 4/23/24 indicated Tenant #1 could feed herself and to assist with eating as needed. She would at times pocket food and staff should attempt to provide food that was easy to chew or was cut up.

A Progress Note dated 4/15/24 indicated Tenant #1 continued to pocket food, and at times coughed on foods and drinks. Tenant #1's weight was down and an order request was sent to the primary care provider (PCP) to admit to hospice.

Further record review revealed a fax to the PCP dated 1/22/24 reflected staff reported Tenant #1 had been pocketing her food, especially meat. An order was received to shred or finely chop all meats.

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A 460	Continued From page 36 An order was received dated 4/22/24 from hospice to change Tenant #1's diet to a moist mechanical ground/soft diet. 3. When interviewed on 4/24/24 at 2:30 p.m. Tenant #1's family member said the tenant had a diet order for soft foods. Meat was to have gravy, catsup, or barbeque sauce. The tenant also pocketed food. When she was there the previous weekend, Tenant #1 was served roast beef that was not cut up and had not gravy or catsup. The family member heard the staff yelling at Tenant #1 that she needed to swallow. The family member came out and observed Tenant #1's mouth was packed full. She told staff to get the food out and reported it to the Resident Care Coordinator. On 4/24/24 at 2:55 p.m. the Resident Care Coordinator said Tenant #1 was eating finger foods and they were waiting to get an order. She had been pocketing foods and her diet was switched to a blended meat two days ago. She said Tenant #1's family reported on the weekend the family member was in Tenant #1's apartment while Tenant #1 was eating in the dining room. The family member heard Staff F tell Tenant #1 she needed to swallow and chew. The tenant's cheeks were full with food. The family member reported Staff F yelled at Tenant #1 to chew and swallow. No other staff witnessed the incident. When interviewed on 4/25/24 at 12:20 p.m. Staff D said today (4/25/24) was the first meal she assisted Tenant #1 with that had ground meat consistency. She said Tenant #1 had not choked before but the hospice nurse was concerned about aspiration.	A 460		

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A 460	Continued From page 37 When interviewed on 4/24/24 at 9:44 a.m. the Dining Supervisor said there were no special diets. She one tenant was gluten free and they used different toasters and bread. When interviewed again on 4/25/24 at 10:24 a.m. the Dining Supervisor said Tenant #1's diet was switched to blended on 4/22/24 and before that she was given softer foods. She said she got the order today (4/25/24) and was told by hospice on Monday (4/22/24). She had not received any training on the diet or orders from the Program, but had training in her ServSafe course. She said none of the other dietary staff had training on the diet. The corporate registered dietician had not been involved with menu planning and had not been there. She said the food was moistened by putting gravy in it. The consistency was blended. When interviewed on 4/30/24 at approximately 9:10 a.m. the Executive Director said Tenant #1 had a mechanical moist soft diet. She had no choking episodes; however, coughed when she ate. Staff assisted with feeding Tenant #1. She said the hospice nurse went through things with some of the cooks; however, no training was documented by program staff. She said the corporate dietician was not involved with the menu planing. 4. Record review revealed the Program's Dining Services policy and procedure indicated they accommodated specialized diets. A physician and the corporate dietician would sign off on the specialized diet. Training and training materials would be provided to ensure competency of dining of staff. In summary, Tenant #1 was on hospice, staff fed her meals and she pocketed her food. Tenant #1	A 460		

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(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 460	Continued From page 38 was also non-verbal and was staged at a seven on the GDS. She had an order dated 1/22/24 for shredded or cut up meats. On 4/22/24 an order for a moist mechanical ground diet was received. Tenant #1's family reported she was served roast beef the weekend prior that was not cut up and did not have a sauce on it; she had a mouth full of food and staff yelled at her to chew and swallow. Tenant #1 did not receive food as ordered when observed at the lunch meal on 4/24/24. Dietary staff had not received training from the Program on how to prepare Tenant #1's food as ordered. Additionally, there was no involvement by a dietician regarding the menu planning for the therapeutic diet and the dietician had not signed off on the diet.	A 460		
A 465	481-69.28(5) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure staff completed an annual in-service on food protection. This pertained to 3 of 3 staff reviewed who were employed longer than one year (Staff A, Staff C and Staff K). Findings follow: 1. When observed on 4/24/24 at 11:10 a.m. Staff C was serving the lunch meal in memory care. She brought coffee cups to the table twice and	A 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0335	A. BUILDING: _____ B. WING _____	C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF ALGONA	512 N FINN DRIVE ALGONA, IA 50511

(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 465	Continued From page 39 touched the top of the cups. Staff K was also present at the meal and assisted with feeding Tenant #1. 2. Review of Staff A's training documents on 4/24/24 revealed a hire date of 3/28/23. Staff A had food safety training last completed on 4/12/23. Staff A did not have food safety training completed annually. 3. Review of Staff C's training documents on 4/24/24 revealed Staff C was hired on 9/27/16. Staff A had food safety training last completed on 3/14/22. Staff C did not have food safety training completed annually. 4. Review of Staff K's training documents on 4/24/24 revealed Staff K was hired on 5/7/20. Staff K had food safety training last completed on 3/13/22. 5. When interviewed on 4/24/24 at approximately 1:55 p.m. and 4/30/24 at approximately 9:10 a.m. the Executive Director confirmed the staff above served food and all food safety training was provided. She also confirmed she was not aware of the requirement for food safety training to be completed annually. She said the staff had it upon hire.	A 465		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.	A 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0335	A. BUILDING: _____ B. WING _____	C 04/30/2024

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HOMESTEAD OF ALGONA	512 N FINN DRIVE ALGONA, IA 50511

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A 545	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure all staff had eight hours of dementia-specific education and training within 30 days of employment. This pertained to 5 of 9 direct care staff reviewed hired in the past year (Staff J, I, H, F, E, G). Findings include: 1. Review of Staff J's training documents on 4/23/24 revealed a hire date of 1/10/24. Staff J did not have eight hours of dementia-specific education and training within 30 days of employment or at the time of this review. 2. Review of Staff I's training documents on 4/23/24 revealed a hire date of 11/15/23. Staff I did not have eight hours of dementia-specific education within 30 days of employment or at the time of the review. 3. Review of Staff H's training documents on 4/23/24 revealed a hire date of 2/16/24. Staff H did not have eight hours of dementia-specific education and training within 30 days of employment or at the time of the review. 4. Review of Staff E's training documents on 4/23/24 revealed a hire date of 2/12/24. Staff E had dementia training documented on 2/15/24. Staff E had four hours of dementia training documented within 30 days of employment. 5. Review of Staff G's training documents on 4/23/24 revealed a hire date of 10/6/23. Staff G did not have eight hours of dementia-specific education and training within 30 days of employment or at the time of the review.	A 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0335	A. BUILDING: _____ B. WING _____	C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 545	Continued From page 41 6. When interviewed on 4/30/24 at approximately 9:10 a.m. the Executive Director confirmed all dementia education was provided for the staff reviewed.	A 545		
A 556	481-69.30(3)b Dementia-Specific Education for Personnel 69.30(3) Dementia-specific continuing education b. Direct-contact personnel employed by or contracting with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff completed eight hours of dementia-specific training annually. This pertained to 2 of 2 direct care staff reviewed employed greater than one year (Staff D and Staff K). Findings follow: 1. Review of Staff D's training documents on 4/30/24 revealed a hire date of 1/23/23. A Dementia Case Study dated 2/22/23 and an undated self-directed learning module were provided. It could not be determined how many hours of dementia training Staff D received in the past year. 2. Review of Staff K's training documents on 4/30/24 revealed a hire date of 5/7/20. A	A 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0335	A. BUILDING: _____ B. WING _____	C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF ALGONA	**512 N FINN DRIVE ALGONA, IA 50511**

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A 556	Continued From page 42 Dementia Case Study (undated) and a self-directed learning module dated 5/19/23 was provided. It could not be determined how many hours of dementia training Staff K received in the past year. 3. When interviewed on 4/30/24 at approximately 9:10 a.m. the Executive Director confirmed all dementia training was provided for the staff reviewed.	A 556		

Plan of Correction for Homestead of Algona

Survey Completion Date: 4/30/2024

A325 481-67.9 (1) Staffing

1. Tenant # 2 has since been discharged from the program.
2. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This will include a float staff when needed.
3. All tenants needs to be reviewed to determine appropriate staffing by director, nurse, or designee periodically.
4. Date of compliance: September 2nd, 2024.

A 345 481-67.9 (4) b Staffing

67.9 Nurse Delegation Procedures

1. Staff E is no longer employed. Staff G, H, I and J will have nurse delegations completed by September 2nd, 2024. Delegations to include training on anti-coagulation medications and hyper and hypoglycemia.
2. Within 30 days of employment, all program nursing staff shall receive training by the program's registered nurse.
3. Employee files are to be audited by director, or designee periodically, but no less than annually to determine compliance with nurse delegation procedures.
4. Date of compliance: September 2nd, 2024.

A 400 481-67.19 (3) Record Checks

1. Staff G's record check was completed with no record found.
2. All staff will have completed background checks completed prior to hire.
3. Employee files will be audited by the director, or designee periodically, but no less than annually to determine compliance with record check procedures.
4. Date of compliance: September 2nd, 2024.

A 145 481-69.22 (3) Evaluation of Tenant

1. Tenant 2 has been discharged. Tenants 1, 3 and 4 have all had significant change evaluations completed.
2. The evaluation of all tenants will be done annually and with significant change. The program will evaluate each tenant 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: September 2nd, 2024.

A 290 481-69.25 (1) Tenant Documents

1. Tenant numbers 2 and 5 have been discharged, and tenants 1, 3, 4 and 6 have nurses notes to reflect any changes by exception.
2. For all tenants, when any personal or health related care is delegated to the program, the program will update the medical information sheet, documentation of healthcare professionals' orders, such as those for treatment, therapy, and mediation; *and nurses' notes written by exception*.
3. Tenant files will be audited periodically by the director or designee to determine compliance with tenant document criteria, to include at a minimum nurse's notes written by exception.
4. Date of compliance: September 2nd, 2024.

A 320 481-69.25(1) o Tenant Documents

1. Education will be done with the Resident Care Coordinator and nursing staff on completion of incident reporting.
2. Incident reports will be completed for each incident involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record)
3. Tenant files will be audited periodically by the director or designee to determine compliance with tenant document criteria, to include incident reporting criteria.
4. Date of compliance: September 2nd, 2024.

A 350 481-69.26 (1) Service Plan

1. Tenant numbers 2 and 5 have been discharged, and tenants 1, 3, and 4 have had service plan updates to reflect their current needs based on accurate assessments.
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: September 2nd, 2024.

A 430 481-69.27 (1) c Nurse Review

1. Tenant number 5 has been discharged and Tenant number 1 has had a 90-day nurse review completed.
2. All tenants will have nurse reviews completed to assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status.
3. Tenant files will be audited periodically by the director or designee to determine compliance with nurse reviews.
4. Date of compliance: September 2nd, 2024.

A 460 481-69.28 (4) Food Service

1. Tenant number 1's specialized diet has been signed off on by the corporate dietician and training and training materials have been provided to ensure dining competency of staff.
2. Any tenants having specialized diets will be prescribed by a physician and be signed off on by the corporate dietician and training and training materials will be provided to ensure dining competency of staff.
3. Tenant files will be audited periodically by the director or designee to determine compliance with specialized diets.
4. Date of compliance: September 2nd, 2024.

A465 481-69.28 (5) Food Service

1. Staff A and C have completed annual training on food protection. Staff K in no longer employed.
2. All food service personnel who are employed or contracted by the program and are responsible for food preparation or service, will have an orientation on sanitation and safe food handling prior to handling food and will have an annual training on food protection, thereafter.
3. Staff files will be audited by the director, or designee periodically, but no less than annually to determine compliance with annual food protection training.
4. Date of compliance: September 2nd, 2024.

A 545 481-69.30 (1) Dementia Specific Education for Personnel

1. Staff E is no longer employed. Staff J, I, H, F, and G have all completed 8 hours of dementia specific training and education.
2. The Program will ensure all staff have 8 hours of dementia specific training and education upon hire, within 30 days and annually, thereafter.
3. Staff files will be audited by the director, or designee periodically, but no less than annually to determine compliance with dementia specific training and education.
4. Date of compliance: September 2nd, 2024.

Plan of Correction for Homestead of Algona

Survey Completion Date: 4/30/2024

A325 481-67.9 (1) Staffing

1. Tenant # 2 has since been discharged from the program.
2. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This will include a float staff when needed.
3. All tenants needs to be reviewed to determine appropriate staffing by director, nurse, or designee periodically.
4. Date of compliance: September 2nd, 2024.

A 345 481-67.9 (4) b Staffing

67.9 Nurse Delegation Procedures

1. Staff E is no longer employed. Staff G, H, I and J will have nurse delegations completed by September 2nd, 2024. Delegations to include training on anti-coagulation medications and hyper and hypoglycemia.
2. Within 30 days of employment, all program nursing staff shall receive training by the program's registered nurse.
3. Employee files are to be audited by director, or designee periodically, but no less than annually to determine compliance with nurse delegation procedures.
4. Date of compliance: September 2nd, 2024.

A 400 481-67.19 (3) Record Checks

1. Staff G's record check was completed with no record found.
2. All staff will have completed background checks completed prior to hire.
3. Employee files will be audited by the director, or designee periodically, but no less than annually to determine compliance with record check procedures.
4. Date of compliance: September 2nd, 2024.

A 145 481-69.22 (3) Evaluation of Tenant

1. Tenant 2 has been discharged. Tenants 1, 3 and 4 have all had significant change evaluations completed.
2. The evaluation of all tenants will be done annually and with significant change. The program will evaluate each tenant 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: September 2nd, 2024.

A 290 481-69.25 (1) Tenant Documents

1. Tenant numbers 2 and 5 have been discharged, and tenants 1, 3, 4 and 6 have nurses notes to reflect any changes by exception.
2. For all tenants, when any personal or health related care is delegated to the program, the program will update the medical information sheet, documentation of healthcare professionals' orders, such as those for treatment, therapy, and mediation; *and nurses' notes written by exception*.
3. Tenant files will be audited periodically by the director or designee to determine compliance with tenant document criteria, to include at a minimum nurse's notes written by exception.
4. Date of compliance: September 2nd, 2024.

A 320 481-69.25(1) o Tenant Documents

1. Education will be done with the Resident Care Coordinator and nursing staff on completion of incident reporting.
2. Incident reports will be completed for each incident involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record)
3. Tenant files will be audited periodically by the director or designee to determine compliance with tenant document criteria, to include incident reporting criteria.
4. Date of compliance: September 2nd, 2024.

A 350 481-69.26 (1) Service Plan

1. Tenant numbers 2 and 5 have been discharged, and tenants 1, 3, and 4 have had service plan updates to reflect their current needs based on accurate assessments.
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: September 2nd, 2024.

A 430 481-69.27 (1) c Nurse Review

1. Tenant number 5 has been discharged and Tenant number 1 has had a 90-day nurse review completed.
2. All tenants will have nurse reviews completed to assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status.
3. Tenant files will be audited periodically by the director or designee to determine compliance with nurse reviews.
4. Date of compliance: September 2nd, 2024.

A 460 481-69.28 (4) Food Service

1. Tenant number 1's specialized diet has been signed off on by the corporate dietician and training and training materials have been provided to ensure dining competency of staff.
2. Any tenants having specialized diets will be prescribed by a physician and be signed off on by the corporate dietician and training and training materials will be provided to ensure dining competency of staff.
3. Tenant files will be audited periodically by the director or designee to determine compliance with specialized diets.
4. Date of compliance: September 2nd, 2024.

A465 481-69.28 (5) Food Service

1. Staff A and C have completed annual training on food protection. Staff K in no longer employed.
2. All food service personnel who are employed or contracted by the program and are responsible for food preparation or service, will have an orientation on sanitation and safe food handling prior to handling food and will have an annual training on food protection, thereafter.
3. Staff files will be audited by the director, or designee periodically, but no less than annually to determine compliance with annual food protection training.
4. Date of compliance: September 2nd, 2024.

A 545 481-69.30 (1) Dementia Specific Education for Personnel

1. Staff E is no longer employed. Staff J, I, H, F, and G have all completed 8 hours of dementia specific training and education.
2. The Program will ensure all staff have 8 hours of dementia specific training and education upon hire, within 30 days and annually, thereafter.
3. Staff files will be audited by the director, or designee periodically, but no less than annually to determine compliance with dementia specific training and education.
4. Date of compliance: September 2nd, 2024.