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 07/17/2025

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 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 visit. Number of tenants without cognitive impairment: 27 Number of tenants with cognitive impairment: 7 Total census: 34 The following regulatory insufficiencies were cited during the investigations of #129958-C.	A 000	See attached POC 8/31/25	
A 215	481-67.4(3) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(3) When there is an act that causes major injury to a tenant or when a program has knowledge of a pattern of acts committed by the same tenant on another tenant that results in any physical injury. For the purposes of this subrule, "pattern" means two or more times within a 30-day period. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to report an incident of tenant aggression resulting in a major injury to another tenant, involving 2 of 4 tenants reviewed (Tenant #1 and Tenant #2). Finding follows: On 7/16/25 review of an incident report (IR) dated 7/01/25 revealed Staff A heard a scream as she	A 215		

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A 215	Continued From page 1	A 215		

returned to the common area from a tenant's room. Tenant #1 had pushed Tenant #2 to the floor. Staff assisted Tenant #2 from the floor and notified her daughter. Tenant #2's daughter took her to the emergency department (ED) due to complaints of pain in left hand and left hip.

Tenant #2's nursing progress note dated 7/01/25 indicated x-rays at the ED revealed fractures of the metacarpal (bone in hand) and phalanx left right finger. According to a progress note on 7/03/25, Tenant #2 complained of pain in left hip/groin, but a hip x-ray done at ED had not indicated a fracture. A progress note dated 7/09/25 indicated Tenant #2 was seen by an orthopedist and additional tests revealed a fracture to her left pelvis. No additional progress notes were documented after the entry on 7/09/25.

During interview on 7/16/25 at 7:30 p.m. Tenant #2's daughter stated she was notified by the Resident Care Coordinator/Licensed Practical Nurse (LPN) another tenant pushed her mother to the floor. Tenant 2's daughter said prior to the fall on 7/01/25, her mother was independently ambulatory and could use the toilet on her own. After the fall, she began using a wheelchair and needed assistance with toileting. Tenant #2 got a cast on her hand on 7/07/25 and also needed additional assistance with showering and dressing.

During interview on 7/16/25 at 4:40 p.m. the Executive Director (ED) and LPN confirmed the program failed to notify the Department of Inspections, Appeals and Licensing (DIAL) of the incident on 7/01/25 when Tenant #1's act of aggression caused a major injury to Tenant #2. The ED stated she viewed the surveillance video

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A 215	Continued From page 2 of the incident and saw the two tenants involved in a physical altercation. She indicated Tenant #1 and Tenant #2 each had a hold of the other's arms and were tussling when Tenant #1 swung Tenant #2 to the floor. (The video was no longer available at the time of the DIAL investigation.) When asked why the program failed to report the incident, the ED stated she checked with their corporate office and was told they didn't need to report it.	A 215		
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 observation, interview and record review, the program failed to update service plans related to significant change of condition for 2 of 4 tenants reviewed (Tenant #2 and Tenant #3). 1. On 7/16/25 review of an incident report (IR) dated 7/01/25 revealed Staff A heard a scream as she returned to the common area from a tenant's room. Tenant #1 had pushed Tenant #2 to the floor. Staff assisted Tenant #2 from the floor and notified her daughter. Tenant #2's daughter took	A 350		

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A 350	Continued From page 3	A 350		

her to the emergency department (ED) due to complaints of pain in left hand and left hip.

Tenant #2's nursing progress note dated 7/01/25 indicated x-rays at the ED revealed fractures of the metacarpal (bone in hand) and phalanx left right finger. According to a progress note on 7/03/25, Tenant #2 complained of pain in left hip/groin, but a hip x-ray done at ED had not indicated a fracture. A progress note dated 7/09/25 indicated Tenant #2 was seen by an orthopedist and additional tests revealed a fracture to her left pelvis. No additional progress notes were documented after the entry on 7/09/25.

During an interview on 7/16/25 at 2:35 p.m. Staff B stated Tenant #1 and Tenant #2 had an altercation a couple of weeks ago which resulted in a broken hand and pelvis for Tenant #2. Staff B noted Tenant #2 previously walked on her own, but used a wheelchair since the fall/fracture.

During an interview on 7/16/25 at 7:30 p.m. Tenant #2's daughter stated she was notified by the Resident Care Coordinator/Licensed Practical Nurse (LPN) another tenant pushed her mother to the floor. Tenant 2's daughter said prior to the fall on 7/01/25, her mother was independently ambulatory and could use the toilet on her own. After the fall, she began using a wheelchair and needed assistance with toileting. Tenant #2 could no longer stand on her own. She got a cast on her hand on 7/07/25 and also needed additional assistance with showering and dressing. Tenant 2's daughter stated she and her sister requested a meeting and met with the Executive Director (ED) and the LPN on 7/09/25 after learning of the pelvis fracture. Tenant #2's daughter said they met to discuss a new care plan regarding their

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A 350	Continued From page 4	A 350		

mother's needs since the fall/fractures. The daughter stated she hadn't received or seen an updated service plan since the meeting on 7/09/25. Tenant #2's daughters had power of attorney.

During an interview on 7/17/25 at 9:00 a.m. Staff C said since Tenant #2's hand and hip/pelvic fracture, her needs had increased. She needed help getting off and on the toilet and more help with showering. Tenant #2 had previously been independent with transfers and ambulation, but now used a wheelchair and needed assistance with transfers.

On 7/16/25 the most recent service plan in Tenant #2's record was her 30-day service plan, completed 5/29/25. According to the service plan, Tenant #2 was independent with mobility, transfers and toileting. The plan indicated she needed reminders to change her clothes and physical assistance to bathe/shower, but she didn't have a cast on her hand at that time, so those needs were not addressed. An updated service plan could not be located in Tenant #2's chart.

During an interview on 7/16/25 at 4:40 p.m. the ED and LPN confirmed the program failed to update Tenant #2's service plan since her change in condition. The LPN said she had been working on new assessments for Tenant #2, but was unable to produce them on 7/16/25.

2. Observation on 7/16/25 at 2:30 p.m. revealed Tenant #3 in a high back wheelchair, in the memory care common area.

During an interview on 7/16/25 at 2:35 p.m. Staff A stated Tenant #3 was under hospice care. She

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A 350	Continued From page 5 said Tenant #3 typically required the assistance of two staff to transfer her. Staff A noted Tenant #3 had been in the wheelchair since 10:00 a.m. that morning. During an interview on 7/17/25 at 9:00 a.m. Staff C said it had been several weeks since Tenant #3 was able to ambulate and transfer without assistance. She had primarily been using a wheelchair for a few weeks. During an interview on 7/17/25 at 10:25 a.m. Staff D stated it had been 4-6 weeks since Tenant #3 ambulated and transferred on her own. Record review on the morning of 7/17/25 revealed the most recent service plan in Tenant #3's chart was dated 12/15/24. The service plan noted Tenant #3 received hospice care. According to the service plan, Tenant #3 was independently ambulatory. Assessments completed on 6/13/25 indicated Tenant #3 needed assistance with transfers and mobility, but an updated service plan could not be located in her chart. During an interview on 7/17/25 at 11:45 a.m., the ED and LPN confirmed the lack of an updated service plan in Tenant #3's record. The LPN said she thought they updated the service plan on 6/13/25 when they completed new assessments. However, she was unable to locate the June service plan. The ED provided an updated service plan dated 7/17/25.	A 350		

ok
8/18/25

Plan of Correction

Program Name: Homestead of Algona
Survey/Inspection Date: 7/30/2025

A215 481-67.4 (3) Program Notification

1. Notification of the incident that occurred on 7/1/25 was reported and investigated by DIAL during complaint visit 7/16/25. All incident reports going forward, that meet program notification requirements will be reported to the department within 24 hours of occurrence.
2. All staff will be re-educated on major injury incidents and incidents requiring program notification.
3. The Administrator (or designee) will review all incident reports within 24 hours of completion to ensure notification requirements have been met and will be reviewed with QI team periodically.
4. Date of compliance: August 31st, 2025

A350 481-69.26 (1) Service Plans

1. Tenants #1 and #2 have had service plan updates, based on current evaluations.
2. All evaluations will trigger a service plan update, unless there are no changes to the evaluation. Any changes will then be reflected in the service plan.
3. The administrator or designee will review any updated evaluations to ensure that service plans are updated, no less than weekly.
4. Date of compliance: August 31st, 2025