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
	S0352	A. BUILDING: _____ B. WING _____	C 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF ESTHERVILLE	2015 3RD AVENUE NORTH ESTHERVILLE, IA 51334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 24 Tenants with cognitive impairment: 11 Total census: 35 The following regulatory insufficiencies were cited during the investigation of Incidents #127785-I, #128679-I, and Complaint #128522-C.	A 000	See attached POC 12/31/25	
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 established policy and procedure for sexual relationships between tenants with a cognitive impairment, this affected 2 of 2 cognitively-impaired tenants (Tenant C1 and Tenant #2). Findings follow: Record review on 8/27/25 revealed an incident report, dated 5/06/25, indicated staff performed hourly checks and observed Tenant C1 in Tenant #2's room after staff heard a noise coming from Tenant #2's room. Tenant C1 was naked and Tenant #2 was naked from the waist down. Tenant C1 laid on top of Tenant #2 in bed. Tenant C1 immediately fell from the bed upon staff	A 150		

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A 150	Continued From page 1	A 150		

entering the room. Staff immediately assisted in separating and redirecting the tenants, evaluated for injuries, and notified program leadership. The report indicated Tenant C1 bled from his arm/elbow from the fall and was sent out to the emergency room (ER) for further evaluation. Nursing progress notes for both tenants noted the incident and notifications to tenant representatives. The nursing progress note for Tenant #2 noted the program encouraged an evaluation for Tenant #2 at the emergency room, but the tenant's representative declined and stated she had no concerns.The Program's former Health Care Coordinator assessed both tenants following the incident.

Tenant C1's chart indicated on 4/08/24, Tenant C1 admitted to the Program and his diagnoses included Alzheimer's Disease, depression, and anxiety disorder. The Service Plan dated 4/01/25, noted Tenant C1's Global Deterioration Score (GDS) of 5, which indicated moderately severe cognitive decline and included "resides in memory care." Tenant C1 later discharged from the program on 5/19/25.

Tenant #2's chart indicated on 11/17/23, Tenant #2 admitted to the Program and her diagnoses included Alzheimer's disease, unspecified dementia of unspecified severity without behavioral, psychotic, mood disturbance, or anxiety. The Service Plan, dated 4/03/25, noted Tenant #2's GDS score of 5, which indicated moderately severe cognitive decline and included "resides in memory care."

Continued review revealed the Program policy, Sexual Relationship between Residents with Cognitive Impairment, undated, included the

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A 150	Continued From page 2 following action steps: a. Cognitive impairment for purposes of this policy would be considered those residents with a GDS score of 5 or above. b. If staff suspect of observe sexual relations between residents where at least one resident has cognitive impairment, they will notify the nurse on call immediately. c. The Resident Care Coordinator will notify the resident's physician, Power of Attorney, and Regional Nurse and/or Regional Vice President. d. The resident's physician will determine if the resident has the capacity to consent. The Power of Attorney will be notified of the physician's decision. e. The physician's decision regarding capacity to consent will be kept in the resident's clinical record. During an interview on 8/28/25 at 8:55 a.m., the Executive Director and interim Health Care Coordinator, both stated they were unaware if the program's former Resident Care Coordinator contacted each tenant's physician and/or whether a determination was made by each tenant's physician to determine consent. No documentation of physician notification or determination of consent could be located. On 8/28/25 at 9:20 a.m., the Executive Director and interim Health Care Coordinator confirmed the above findings.	A 150		
A 215	481-69.24(1)a Involuntary Transfer from Program 69.24(1) Program initiation of transfer. If a program initiates the involuntary transfer of a tenant and the action is not the result of a	A 215		

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A 215	Continued From page 3	A 215		

monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply:

a. The program shall notify the tenant or tenant's legal representative, in accordance with the occupancy agreement, of the need to transfer the tenant and of the reason for the transfer and shall include the contact information for the office of long-term care ombudsman.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the program failed to include accurate contact information for the office of the long-term care ombudsman when serving an involuntary discharge notice for 1 of 1 discharged tenants reviewed (Tenant C1). Finding follows:

Record review on 8/27/25 revealed Tenant C1's 30-day discharge letter, dated 4/25/25, the Program provided an involuntary discharge notice in accordance with the occupancy agreement of the need to transfer, the reason for the discharge, and some contact information for the office of the long-term care ombudsman to the spouse of Tenant C1.

During a phone interview on 8/28/25 with a representative of the long-term care ombudsman's office, the representative indicated while she first became aware on 4/25/25 and received a copy of the notice of the involuntary discharge from the Program, the notice included an incorrect address and phone number for the ombudsman's office. The representative from the

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A 215	Continued From page 4 Ombudsman office immediately called the Program and spoke with the former Executive Director. She provided further education on the correct contact information and provided suggestions/instructions to the program as she indicated the discharge notice did not include specific instances of behaviors, attempted remedies, and included no discussion of a safe and orderly discharge plan for the tenant. The Ombudsman was able to connect with family representatives of Tenant C1 and the family were working with the Program on the discharge. The Ombudsman stated no new notice with the correct contact information was provided by the Program. On 8/28/25 at 9:20 am, the Executive Director and interim Health Care Coordinator confirmed the above findings.	A 215		
A 220	481-69.24(1)b Involuntary Transfer from Program 69.24(1) Program initiation of transfer. If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply: b. The program shall immediately provide to the office of long-term care ombudsman, by certified mail, a copy of the notification and notify the tenant's treating physician, if any. This REQUIREMENT is not met as evidenced by:	A 220		

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A 220	Continued From page 5 Based on interview and record review, the program failed to notify the treating physician of an involuntary discharge for 1 of 1 discharged tenants reviewed (Tenant C1). Finding follows: Record review on 8/27/25 revealed Tenant C1's 30-day discharge letter, dated 4/25/25, the Program provided an involuntary discharge notice in accordance with the occupancy agreement of the need to transfer, the reason for the discharge, and some contact information for the office of the long-term care ombudsman. A review of Tenant C1's progress/nursing notes revealed no documentation regarding notice of the involuntary discharge to Tenant C1's treating physician. During an interview on 8/28/25 at 8:55am, the Executive Director stated she was unaware if the former Executive Director or former Health Care Coordinator contacted Tenant C1's treating physician about the involuntary discharge and could not locate documentation of the physician being notified. On 8/28/25 at 9:20 a.m., the Executive Director and interim Health Care Coordinator confirmed the above findings.	A 220		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced	A 635		

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A 635	Continued From page 6 by: Based on interview and record review, the program failed to ensure an operating alarm system was connected to each exit door in the dementia-specific program. This affected 1 of 4 memory care tenants reviewed (Tenant C1), and potentially affected all cognitively-impaired tenants residing in the program. Finding follows: Record review on 8/27/25 revealed Tenant C1's elopement incident report, dated 3/30/25, indicated at 9:50 a.m., Tenant C1 eloped from the memory care unit and was located outside the front entrance of the building. The report indicated Tenant C1 exit seeked and wandered. Staff reported increased confusion and exit seeking behaviors over the past few days. Tenant C1's chart indicated on 4/08/24, Tenant C1 admitted to the Program and his diagnoses included Alzheimer's Disease, depression, and anxiety disorder.The Service Plan,dated 4/01/25, noted Tenant C1's Global Deterioration Score (GDS) of 5, which indicated moderately severe cognitive decline and included "resides in memory care where the doors are secure and alarmed" with an initiation/identified date of 3/05/25. Tenant C1's hourly checks revealed the last recorded observation at 9:07 a.m. Tenant C1's nursing progress note dated 3/30/25, indicated at 10:05 a.m. following the incident Tenant C1's vitals were within normal limits and no apparent injuries. The nursing progress note further noted the tenant had increased confusion over the past few days and exit seeking behaviors. Following the incident, Tenant C1's service plan was reviewed/updated on 4/01/25.	A 635		

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A 635	Continued From page 7	A 635		

Additions to the service plan identified Tenant C1 as a risk for elopement/wandering and included interventions to help prevent further exit-seeking behaviors/attempts. Tenant C1 discharged from the Program on 5/19/25.

Staff A's written statement obtained by the Program at the time of the incident revealed Staff A arrived at the building at 9:55 a.m. on 3/30/25 and observed Tenant C1 standing at the front door alone. When Staff A pulled up in her vehicle, Tenant C1 opened her passenger door and got into the vehicle. Staff A assisted the tenant back into the building to the memory care unit and alerted Program staff. Once Tenant C1 was safely in the unit, Staff A checked the secondary fire exit door. Staff A discovered the door wasn't alarmed, she instructed the staff member on duty in the unit on the proper setting and reset methods for the alarms on the door.

Staff B's written statement obtained by the Program at the time of the incident revealed Staff B worked in the memory care unit of the Program and was only made aware Tenant C1 exited the unit when he was escorted back to the unit by other staff. Staff B recorded the next hourly check at 10:01 a.m. when the tenant returned to the unit. Staff B indicated no alarms alerted her Tenant C1 exited and she assisted another tenant in a room at the back of the unit. Staff B's written statement noted staff determined the alarm/s did not go off on the emergency exit door by the staff bathroom and Tenant C1 exited. The statement further noted the alarm on the door hadn't been properly reset and Staff B didn't know the alarm needed reset.

Staff C's written statement obtained by the

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A 635	Continued From page 8	A 635		

Program at the time of the incident revealed Staff C observed Tenant C1 walking inside with Staff A. Staff A indicated Tenant C1 had been outside. She noted it was "sprinkling' outside, a little chilly, and he did not have a coat on."

During an interview on 8/27/25 at 1:55 p.m., Staff B confirmed she was the staff member on duty in the memory care unit at the time of the elopement and confirmed the information within her written statement. She didn't know Tenant C1 left and the alarm was not on. She explained there was an audible alarm on the door and the alarm was not hooked up to the system, which the alarm company called the Program when the alarm went off. She recalled Tenant C1 had been dressed in a short sleeve shirt, jeans, and slip on shoes. She recalled it being a chilly day.

On 8/28/25, the State Climatologist provided the weather conditions for the date and suspected time of the elopement incident. The temperature between 9:00 a.m. to 10:00 a.m. was 35 to 36 degrees Fahrenheit, with winds out of the north to northwest between 8 to 12 miles per hour (mph), but wind chill temperatures ranged from 28 to 29 degrees Fahrenheit. The conditions were a wintry mix.

A review of the program policy, Electronic Surveillance Systems, indicated each exit door in the dementia-specific program connected to an operating alarm system. The policy indicated the alarms were tested daily.

During an interview on 8/27/25 at 3:00 p.m., the Executive Director explained the secondary door (located by the memory care public bathroom) was not originally wired into the Viking alarm

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A 635	Continued From page 9 system and the door contained a built-in alarm which originally was audible, but did not alert phones. There was also a secondary, louder audible alarm which was mounted to the door as well. The Executive Director indicated it was her understanding both systems did not alarm on the day of the incident, the loud one was stuck in between the on/off setting, and then speculated staff might have thought the other quieter alarm was reset but actually wasn't, as the alarm required a key to reset, so therefore was disarmed. It was ultimately unknown when the alarms may have last been attempted to be reset, and unknown how long both alarms had not been operational. The Executive Director was uncertain if the door alarms were tested routinely, but the maintenance director would check the alarms following an elopement or exit-seeking incident. Following the elopement incident with Tenant C1, the program initiated a form where staff were to check the memory care door alarms and sign off. On 8/28/25 at 9:20 a.m., the Executive Director and interim Health Care Coordinator confirmed the above findings.	A 635		

Homestead of Estherville Plan of Correction

Survey Completion Date: 08/28/2025

A 150 481.67.2(3) Program Policies and procedures

67.3(2) The program shall follow the policies and procedures established by the program

1. Tenant C1 has been discharged from program

2. All staff to be educated on policy and procedure and continued competence will be checked periodically and at least annually.

3. Staff files will be audited periodically by the Executive Director or designee to determine compliance.

4. Date of Compliance: 12/31/25

A 215 481-69.24 (1)a Involuntary Transfer from program.

69.24(1) Program initiation of transfer.

1. Tenant C1 has been discharged from the program

2. Executive Director and Resident Care Coordinator to be educated and continued competency will be checked periodically and at least annually on the procedures of notification of involuntary transfers, to include the office of the State Ombudsman.

3. Date of compliance: 12/31/25

A220 481-69.24(1)b Involuntary transfer from program.

69.24 (1) Program initiation of transfer

1. Tenant C1 has been discharged from the program

2. Executive Director and Resident Care Coordinator to be educated and continued competency will be checked periodically and at least annually on the procedures of notification of involuntary transfers, to include the treating physician.

3. Date of compliance: 12/31/25

A635 481-69.32(2) Life Safey – Emergency Policies/Structure

69.32(2) An Operating alarm system shall be connected to each exit door in a dementia-specific program.

1. Staff education on proper procedures on how to engage alarm systems has been completed. Ongoing education and competency will be checked periodically and at least annually.

2. Staff will check alarms periodically and document.

3. The Executive Director or designee will audit compliance periodically and at least annually.

4. Date of compliance: 12/31/25

This plan of correction is submitted as required under State and Federal law, the submission of this Plan of Corrective does not constitute an admission on the part of the Facility as to the accuracy of the surveyor`s findings or the conclusions drawn there from. The plan of correction does not constitute a deficiency or that the scope and severity regarding the deficiencies cited are correctly applied. Any changes to the Facility policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible by any third party in any civil or criminal action against the Facility or any employee, agent, officer, director, attorney or shareholder of the Facility.