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
	S0428	A. BUILDING: _____ B. WING _____	C 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF OSKALOOSA	2107 SOUTH MARKET STREET OSKALOOSA, IA 52577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 65 Tenants with cognitive impairment: 0 Total census: 65 The following regulatory insufficiencies were cited related to the investigation of Complaint #130950-C, Incident #130944-C and the recertification visit conducted to determine compliance with certification an Assisted Living Program:	A 000	See attached POC 3/11/2026	
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 regarding incident reports. This pertained to 1 of 2 discharged tenants reviewed (Tenant C2). Finding follows: Record review on 12/08/25 revealed Tenant C2's Progress Note dated 12/08/25 indicated staff contacted the nurse on-call after staff responded to a pendant call at 6:45 a.m. Staff found Tenant C2 face down on the bathroom floor. Staff noted Tenant C2 was not breathing and blue in color. Tenant C2 was not using her oxygen at the time of the fall. Tenant C2's spouse (lived in the	A 150		

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A 150	Continued From page 1 apartment) said he called when he saw her fall. Tenant C2 had no vital signs. Staff was instructed to contact emergency medical services for verification. Tenant C2 was a do not resuscitate (DNR). The nurse on-call arrived at the building and confirmed Tenant C2 was deceased. Tenant C2's family was notified and arrived at 7:20 a.m. The family requested her transfer to a funeral home. An incident report was not completed for the 12/08/25 incident of Tenant C2's fall and being found unresponsive. Record review revealed the Program's policy, Incident Reports directed any accidents or unusual occurrences in the building or on the premises that affected tenants would be reported as incidents. An incident report would be completed in detail by the person in charge at the time of the incident. When interviewed on 12/10/25 at 1:29 p.m. the Executive Director indicated Tenant C2's spouse pushed his pendant. It was reported Tenant C2 fell off the toilet onto the floor. Tenant C2 was not wearing her oxygen and did not have her walker. Staff found her unresponsive, called 911 and the nurse (on-call) and the Executive Director was notified by the nurse (on-call). She confirmed an incident report was not completed related to the above incident. She said she assumed the nurse (on-call) knew to do it.	A 150		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed	A 145		

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A 145	Continued From page 2 with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 2 of 4 current tenants reviewed (Tenant #3 and Tenant #4) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Record review on 12/09/25 of Tenant #3's file revealed Progress Notes indicated the following: a. 9/06/25, staff called regarding wanting a follow up on Tenant #3 as he was sent out to the hospital overnight. Tenant #3 was sent to the hospital per his spouse's request due to stroke symptoms. He was admitted to the hospital for a possible cerebral vascular accident (CVA). b. 9/09/25, Tenant #3 returned back to the Program after an acute stay at the hospital (9/6/25 to 9/9/25) for a CVA. c. 9/09/25, a significant change assessment	A 145		

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A 145	Continued From page 3 would be completed in a timely manner. d. 9/11/25, new orders were received for speech therapy (ST), physical therapy (PT) and occupational therapy (OT) to evaluate and treat. e. 9/15/25, a significant change assessment was completed related to the recent hospitalization and start of therapy service. Continued record review revealed an evaluation was completed related to Tenant #3's hospitalization and start of therapy services; however, it was not completed until 9/15/25. Tenant #3 returned from the hospital on 9/09/25 and therapy services were ordered on 9/11/25. 2. Record review on 12/10/25 revealed Tenant #4's Progress Notes indicated the following: a. 10/29/25, there were staff reports from 10/27/25 to 10/29/25 regarding dressing refusals and approaching a male tenant and making sexual comments. b. 10/30/25, staff reported Tenant #4 put her breast in a male tenant's face and made a sexual comment to the tenant. She was redirected to her apartment. c. 11/16/25 (late entry for 11/15/25), staff called at 2:35 a.m. and reported Tenant #4 was in another tenant's apartment and both tenants were unclothed. Staff redirected her back to her apartment. d. 11/17/25, staff reported on 11/14/25 Tenant #4 had confusion related to the time of evening and on 11/15/25 was confused about time and wandered the hallway.	A 145		

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A 145	Continued From page 4 e. 11/18/25, staff reported she displayed sexual behaviors towards another tenant in the common area. Staff redirected her to her apartment. f. 12/08/25, a provider was in the program and addressed family concerns of increased anxiety. Buspirone was increased. Continued record review revealed evaluations were last completed on 7/24/25. A 90-day review was completed on 10/22/25. Evaluations were not completed as needed with Tenant #4's behaviors noted above. 3. Record review on 12/08/25 and 12/09/25 revealed Tenant C1's Progress Notes indicated the following: a. 10/31/25, staff reported Tenant C1 was found in the bathroom and incontinent of bowel. The laundry was completed and he was cleaned up. b. 10/31/25, staff reported he was more disoriented. He could not find his pendant, which was around his neck. c. 11/14/25, staff reported he smoked inside the building. It was discussed with Tenant C1. d. 11/17/25, staff reported Tenant C1 was observed urinating out of the doorway into the patio area. e. 11/20/25, staff reported Tenant C1 had some increased confusion. f. 11/20/25, a nurse was notified by another tenant that Tenant C1 was confused and could not find his vehicle outside. He eventually found it	A 145		

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A 145	Continued From page 5 and left the building. He was asked if he would be able to find his way back and he did not answer. He returned later in the afternoon. g. 11/28/25, staff reported Tenant C1 had incontinence episodes and needed assistance with changing his clothes. h. 12/04/25, Tenant C1 exited the building via the north hall at 2:46 a.m. and was found knocking to be let back into the building. He was not able to give a clear explanation as to why he exited the building. He was taken to the hospital to be checked out. Tenant C1's family was informed Tenant C1 would need to be placed in memory care due to short term memory deficits and him exiting the building during the night. Continued record review revealed evaluations were most recently completed (prior to the elopement) on 11/18/25. Evaluations were not completed as needed with Tenant C1's increased incontinence, increased confusion and disorientation prior to the elopement. 4. Record review on 12/09/25 revealed Tenant C2's Progress Notes indicated the following: a. 10/20/25,Tenant C2 was admitted to the Program. She had weight changes with fluid accumulation to her lung. She had a Pleurx tube drained three times per week by home health and nurses at the Program. b. 10/20/25, she arrived via medic van with emergency medical services (EMS) transporters (she arrived from out of state). She was on eight liters (L) of oxygen per mask. Family reported a needle aspiration of the lung was completed at the hospital (out of state hospital) as the Pleurx	A 145		

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A 145	Continued From page 6 drainage system cap was broken. The family planned to take her tomorrow to the local hospital to have it drained. c. 10/22/25, staff reported Tenant C2 refused to come out for meals. d. 10/23/25, staff assisted with Tenant C2 with grooming and dressing due to weakness and shortness of breath (SOB). e. 10/28/25, staff reported on 10/24/25 Tenant C2 had increased fatigue and refused dressing. f. 10/30/25, an order was received for Pleurx drainage, drain three times weekly, Monday, Wednesday and Friday, not to exceed 1000 milliliters (ml). g. 10/30/25, staff reported Tenant C2 refused to take medications together and refused her anti-embolism hose. h. 11/03/25, staff reported Tenant C2 refused anti-embolism hose, dressing and continued to request room trays. i. 11/04/25, new orders were received including for a manual wheelchair and anti-embolism hose were changed to as needed. j. 11/11/25, Tenant C2 sat in a tripod position with increased dyspnea and complained of epigastric pain. She was able to speak two to three words before catching her breath. She was sent to the hospital. k. 11/12/25, her drain was completed in the emergency department (ED) on 11/11/25 and 800 ml of fluid was removed.	A 145		

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A 145	Continued From page 7 l. 11/17/25, staff reported when Tenant C2 removed her mask to take her medications her oxygen saturation dropped to the low 60 percent (%). A nurse went to the apartment, Tenant C2 was noted to be SOB and anxious. Her oxygen was increased to eight L from six L. After the oxygen mask was replaced and deep breathing her oxygen, her oxygen saturation came up to 86%. m. 11/24/25, her oxygen saturations were in the low 60%. Her provider was in the building and present. Her oxygen came up to 87% with seven L of oxygen. It would drop to the 80 % when she was talking or with activity. n. 11/26/25, a nurse checked on her for the chest tube drainage and she was using the restroom with oxygen and a facemask. The nurse returned at 8:25 a.m., Tenant C2 was brushing her teeth and requested the nurse's assistance. She said she felt like she might pass out. Her oxygen mask was hanging on the walker handle. Her oxygen saturation was 39% on room air. The mask was reapplied and it increased to 87% on eight L of oxygen after about 90 seconds. The nurse assisted with her drain and 900 ml of tea colored draining was removed. o. 11/30/25, staff contacted the nurse regarding Tenant C2 not being compliant with sitting up in bed to get her oxygen increased above 86%. p. 12/01/25, the home health nurse visited. Tenant C2 was "dusky" in color, her oxygen saturation was 56% on eight L of oxygen with respirations at 48. The home health nurse drained 950 ml out of the drain. Her color returned and her oxygen saturation returned to	A 145		

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A 145	Continued From page 8 88% to 95%. A bedside commode was suggested due to Tenant C2 almost passing out walking from the bathroom to the living room. q. 12/05/25, staff reported Tenant C2's oxygen saturation decreased to 86% on 12/04/25. When she was seen by nursing, she was encouraged to take deep breaths through her nose and out of her mouth. r. 12/05/25, the home health nurse was there and 700 ml was drained. Her oxygen saturation was mid 80%. She had facial edema and her blood pressure was 80/58. She was lethargic and opened her eyes briefly for 10 to 15 seconds. The Program nurse and home health nurse both informed her she should be seen in the ED and Tenant C2 declined. They talked to Tenant C2's spouse and he said he wanted to respect her wishes. Tenant C2's family was also informed. s. 12/06/25, staff contacted the nurse on-call regarding Tenant C2's low blood pressure. There were no signs and symptoms of hypotension noted. t. 12/08/25, staff contacted the nurse on-call after staff responded to a pendant call at 6:45 a.m. Staff found Tenant C2 face down on the bathroom floor. Staff noted Tenant C2 was not breathing and blue in color. Tenant C2 was not using her oxygen at the time of the fall. Tenant C2's spouse (lived in the apartment) said he called when he saw her fall. Tenant C2 had no vital signs. Staff was instructed to contact emergency medical services for verification. Tenant C2 was a do not resuscitate (DNR). The nurse on-call arrived at the building and confirmed Tenant C2 was deceased. Tenant C2's family was notified and arrived at 7:20 a.m. The	A 145		

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A 145	Continued From page 9 family requested her transfer to a funeral home. u. 12/08/25 (late entry), staff reported Tenant C2 needed assistance walking to and from the bathroom. v. 12/08/25 (late entry for 12/07/25), staff reported Tenant C2 had swelling to her left arm per usual. She had a hard time walking and needed assistance. Continued record review revealed on 12/05/25 a verbal order received for Pleurx drainage to every other day (increased frequency of drainage), not to exceed 1000 ml drainage. The order to drain three times per week on Monday, Wednesday and Friday was discontinued. Further record review revealed Tenant C2 evaluations signed on 10/20/25 and 11/07/25. Evaluations were not completed as needed with Tenant C2's health decline and with changes as noted above related to her refusals, room trays, deteriorating heath, increased assistance needed for cares, low oxygen saturation and blood pressure readings, non-compliance with oxygen and oxygen saturation levels and an increased frequency to drain the chest tube. When interviewed on 12/10/25 at 11:17 a.m. Registered Nurse #1 confirmed all evaluations were provided for the tenants reviewed.	A 145		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the	A 350		

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A 350	Continued From page 10 specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed with change and reflect the service needs of tenants. This pertained to 4 of 4 current tenants reviewed (Tenants #1, #2, #3 and #4) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Record review on 12/09/25 of Tenant #1's file revealed the evaluation completed on 7/16/25 indicated he had a managed risk in place for refusals of toileting and bathing and refusal to change clothes when he added meals (remained wet or soiled). Tenant #1 had incontinent episodes at meals around others. Progress Notes indicated the following: a. 9/03/25, staff reported Tenant #1 urinated in the dining room chair then attempted to clean it. b. 9/04/25, staff reported Tenant #1 was incontinent of bladder twice in the dining room on 9/04/25. c. 9/08/25, another tenant came into the office and reported she and another tenant were upset about Tenant #1 being incontinent in the dining room and his body odor.	A 350		

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A 350	Continued From page 11 d. 9/09/25, another tenant reported Tenant #1 urinated in the dining room and had a bad odor when leaving the table. e. 9/12/25, staff reported Tenant #1 got up from the chair at the meal and wiped the chair that was soaked with urine with a napkin and put the napkin on the table. f. 9/17/25, staff reported twice he was incontinent of urine at the dining room table and left the chair wet with urine. g. 9/22/25, staff reported he was incontinent in the dining room twice and wiped up urine with a napkin. h. 9/29/25, the primary care provider (PCP) reviewed the 30-day notice given. i. 10/10/25, another tenant came to the office and reported Tenant #1 had urine running down his leg and his pants were "soaking wet." j. 10/22/25, staff reported he refused to leave his apartment and refused the toileting schedule. k. 12/04/25, staff reported he requested a room tray and refused to come down to meals. His walking decreased and he had more difficulty walking to the bathroom. l. 12/08/24, the nurse visited with him regarding frequent requests for room trays, spending the majority of the time in his apartment and staff reported increased weakness. Continued record review revealed Staff	A 350		

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A 350	Continued From page 12 Communication sheets from July to November 2025 indicated documented incidents of care refusals, incontinence including in the dining room and refusals to come out to meals. Further record review revealed Tenant #1 was given a 30-day notice dated 9/19/25 related to his incontinence. Continued record review revealed Tenant #1's service plan dated 7/16/25 failed to reflect he was soiled at times in the dining room, the request for meals to be served in his apartment or increased weakness. 2. Record review on 12/09/25 of Tenant #2's file revealed the service plan dated 7/03/25 reflected Tenant #2 was independent with mobility and transfers. Continued record review revealed the Adult Services Monitoring Entrance Form listed Tenant #2 as a tenant who wandered. When interviewed at the time of the entrance meeting on 12/08/25 leadership staff indicated she was not exit seeking and there were no safety concerns related to Tenant #2. Further record review revealed Tenant #2's service plan did not reflect Tenant #2's wandering behavior. 3. Record review on 12/09/25 of Tenant #3's file revealed Progress Notes indicated the following: a. 9/06/25, staff called regarding wanting a follow up on Tenant #3 as he was sent out to the hospital overnight. Tenant #3 was sent to the hospital per his spouse's request due to stroke	A 350		

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A 350	Continued From page 13 symptoms. He was admitted to the hospital for a possible cerebral vascular accident (CVA). b. 9/09/25, Tenant #3 returned back to the Program after an acute stay at the hospital (9/6/25 to 9/9/25) for a CVA. c. 9/09/25, a significant change assessment would be completed in a timely manner. d. 9/11/25, new orders were received for speech therapy (ST), physical therapy (PT) and occupational therapy (OT) to evaluate and treat. e. 9/15/25, a significant change assessment was completed related to the recent hospitalization and start of therapy service. Continued record review revealed a service plan was updated related to Tenant #3's hospitalization and start of therapy services; however, it was not completed until 9/15/25. Tenant #3 returned from the hospital on 9/09/25 and therapy services were ordered on 9/11/25. 4. Record review on 12/10/25 of Tenant #4's file revealed Progress Notes indicated the following: a. 10/29/25, there were staff reports from 10/27/25 to 10/29/25 regarding dressing refusals and approaching a male tenant and making sexual comments. b. 10/30/25, staff reported Tenant #4 put her breast in a male tenant's face and made a sexual comment to the tenant. She was redirected to her apartment. c. 11/16/25 (late entry for 11/15/25), staff called at 2:35 a.m. and reported Tenant #4 was in	A 350		

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
	S0428	A. BUILDING: _____ B. WING _____	C 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF OSKALOOSA	2107 SOUTH MARKET STREET OSKALOOSA, IA 52577

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A 350	Continued From page 14 another tenant's apartment and both were unclothed. Staff redirected her back to her apartment. d. 11/17/25, staff reported on 11/14/25, Tenant #4 had confusion related to the time of evening and on 11/15/25 was confused about time and wandered the hallway. e. 11/18/25, staff reported she displayed sexual behaviors towards another tenant in the common area. Staff redirected her to her apartment. f. 12/08/25, a provider was in the Program and addressed family concerns of increased anxiety. Buspirone was increased. Continued record review revealed Tenant #4's service plan was last updated on 7/24/25. The service plan was not updated as needed with the behaviors noted above. 5. Record review on 12/08/25 and 12/09/25 of Tenant C1's file revealed Progress Notes indicated the following: a. 10/31/25, staff reported Tenant C1 was found in the bathroom and incontinent of bowel. The laundry was completed and he was cleaned up. b. 10/31/25, staff reported he was more disoriented. He could not find his pendant, which was around his neck. c. 11/14/25, staff reported he smoked inside the building. It was discussed with Tenant C1. d. 11/17/25, staff reported Tenant C1 was observed urinating out of the doorway into the patio area.	A 350		

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A 350	Continued From page 15 e. 11/20/25, staff reported Tenant C1 had some increased confusion. f. 11/20/25, a nurse was notified by another tenant that Tenant C1 was confused and could not find his vehicle outside. He eventually found it and left the building. He was asked if he would be able to find his way back and he did not answer. He returned later in the afternoon. g. 11/28/25, staff reported Tenant C1 had incontinence episodes and needed assistance with changing his clothes. h. 12/04/25, Tenant C1 exited the building via the north hall at 2:46 a.m. and was found knocking to be let back into the building. He was not able to give a clear explanation as to why he exited the building. He was taken to the hospital to be checked out. Tenant C1's family was informed Tenant C1 would need to be placed in memory care due to short term memory deficits and him exiting the building during the night. Continued record review revealed Tenant C1's service plan recently updated (prior to the elopement) on 11/18/25. The service plan was not updated as needed with Tenant C1's increased incontinence, increased confusion and disorientation prior to the elopement. 6. Record review on 12/09/25 revealed Tenant C2's Progress Notes indicated the following: a. 10/20/25,Tenant C2 was admitted to the Program. She had weight changes with fluid accumulation to her lung. She had a Pleurx tube drained three times per week by home health and nurses at the Program.	A 350		

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A 350	Continued From page 16 b. 10/20/25, she arrived via medic van with emergency medical services (EMS) transporters (she arrived from out of state). She was on eight liters (L) of oxygen per mask. Family reported a needle aspiration of the lung was completed at the hospital (out of state hospital) as the Pleurx drainage system cap was broken. The family planned to take her tomorrow to the local hospital to have it drained. c. 10/22/25, staff reported Tenant C2 refused to come out for meals. d. 10/23/25, staff assisted with Tenant C2 with grooming and dressing due to weakness and shortness of breath (SOB). e. 10/28/25, staff reported on 10/24/25 Tenant C2 had increased fatigue and refused dressing. f. 10/30/25, an order was received for Pleurx drainage, drain three times weekly, Monday, Wednesday and Friday, not to exceed 1000 milliliters (ml). g. 10/30/25, staff reported Tenant C2 refused to take medications together and refused her anti-embolism hose. h. 11/03/25, staff reported Tenant C2 refused anti-embolism hose, dressing and continued to request room trays. i. 11/04/25, new orders were received including for a manual wheelchair and anti-embolism hose were changed to as needed. j. 11/11/25, Tenant C2 sat in a tripod position with	A 350		

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A 350	Continued From page 17 increased dyspnea and complained of epigastric pain. She was able to speak two to three words before catching her breath. She was sent to the hospital. k. 11/12/25, her drain was completed in the emergency department (ED) on 11/11/25 and 800 ml of fluid was removed. l. 11/17/25, staff reported when Tenant C2 removed her mask to take her medications her oxygen saturation dropped to the low 60 percent (%). A nurse went to the apartment, Tenant C2 was noted to be SOB and anxious. Her oxygen was increased to eight L from six L. After the oxygen mask was replaced and deep breathing her oxygen, her oxygen saturation came up to 86%. m. 11/24/25, her oxygen saturations were in the low 60%. Her provider was in the building and present. Her oxygen came up to 87% with seven L of oxygen. It would drop to the 80 % when she was talking or with activity. n. 11/26/25, a nurse checked on her for the chest tube drainage and she was using the restroom with oxygen and a facemask. The nurse returned at 8:25 a.m., Tenant C2 was brushing her teeth and requested the nurse's assistance. She said she felt like she might pass out. Her oxygen mask was hanging on the walker handle. Her oxygen saturation was 39% on room air. The mask was reapplied and it increased to 87% on eight L of oxygen after about 90 seconds. The nurse assisted with her drain and 900 ml of tea colored draining was removed. o. 11/30/25, staff contacted the nurse regarding Tenant C2 not being compliant with sitting up in	A 350		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 350	Continued From page 18 bed to get her oxygen increased above 86%. p. 12/01/25, the home health nurse visited. Tenant C2 was "dusky" in color, her oxygen saturation was 56% on eight L of oxygen with respirations at 48. The home health nurse drained 950 ml out of the drain. Her color returned and her oxygen saturation returned to 88% to 95%. A bedside commode was suggested due to Tenant C2 almost passing out walking from the bathroom to the living room. q. 12/05/25, staff reported Tenant C2's oxygen saturation decreased to 86% on 12/04/25. When she was seen by nursing, she was encouraged to take deep breaths through her nose and out of her mouth. r. 12/05/25, the home health nurse was there and 700 ml was drained. Her oxygen saturation was mid 80%. She had facial edema and her blood pressure was 80/58. She was lethargic and opened her eyes briefly for 10 to 15 seconds. The Program nurse and home health nurse both informed her she should be seen in the ED and Tenant C2 declined. They talked to Tenant C2's spouse and he said he wanted to respect her wishes. Tenant C2's family was also informed. s. 12/06/25, staff contacted the nurse on-call regarding Tenant C2's low blood pressure. There were no signs and symptoms of hypotension noted. t. 12/08/25, staff contacted the nurse on-call after staff responded to a pendant call at 6:45 a.m. Staff found Tenant C2 face down on the bathroom floor. Staff noted Tenant C2 was not breathing and blue in color. Tenant C2 was not using her oxygen at the time of the fall. Tenant	A 350		

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A 350	Continued From page 19 C2's spouse (lived in the apartment) said he called when he saw her fall. Tenant C2 had no vital signs. Staff was instructed to contact emergency medical services for verification. Tenant C2 was a do not resuscitate (DNR). The nurse on-call arrived at the building and confirmed Tenant C2 was deceased. Tenant C2's family was notified and arrived at 7:20 a.m. The family requested her transfer to a funeral home. u. 12/08/25 (late entry), staff reported Tenant C2 needed assistance walking to and from the bathroom. v. 12/08/25 (late entry for 12/07/25), staff reported Tenant C2 had swelling to her left arm per usual. She had a hard time walking and needed assistance. Continued record review revealed on 12/05/25 a verbal order received for Pleurx drainage to every other day (increased frequency of drainage), not to exceed 1000 ml drainage. The order to drain three times per week on Monday, Wednesday and Friday was discontinued. Further record review revealed Tenant C2 evaluations signed on 10/20/25 and 11/07/25. Evaluations were not completed as needed with Tenant C2's health decline and with changes as noted above related to her refusals, room trays, deteriorating heath, increased assistance needed for cares, low oxygen saturation and blood pressure readings, non-compliance with oxygen and oxygen saturation levels and an increased frequency to drain the chest tube. When interviewed on 12/10/25 at 11:17 a.m. Registered Nurse #1 confirmed Tenant #1's service plan was not specific to issues with	A 350		

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A 350	Continued From page 20 incontinence in the dining room and she said the meal tray was a new issue. She indicated Tenant #2 wandered with a purpose and if she was bored. She confirmed 9/15/25 was the most recent service plan for Tenant #3. Regarding Tenant #4, it was a mutual relationship between her and a male tenant. She confirmed the 7/24/25 service plan was the most recent for Tenant #4. She also confirmed Tenant C2's most recent service plan was 11/07/25. She confirmed all of the service plans were provided for the tenants reviewed.	A 350		

Plan of Correction for Homestead of Oskaloosa Assisted Living

Survey Completion date: 12/10/25

A150 481-67.2(3) Program Policies and Procedures

67.2(3) The program shall follow the policies and procedures established by the program.

1. Tenant C2 has been discharged from the program.
2. All program staff shall receive training on incident reporting to include falls, accidents and unusual occurrences.
3. Incident reports will be completed by the person in charge at the time of the incident.
4. Date of Compliance: March 11, 2026

A145 481.69.22(3) Evaluation of Tenant

69.22(3) Evaluation annually and with significant change

1. Tenants C1 and C2 have been discharged from the program. Tenants #3 and #4 have had significant change evaluations completed.
2. The evaluation of all tenants will be done prior to or on admission, within 30 days, at least annually and with significant change. The program will evaluate each tenant's functional, cognitive and health status.
3. Tenant files will be audited periodically by the director or designee to determine compliance with evaluation of tenant.
4. Date of compliance: March 11, 2026

A350 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.

1. Tenants # 1, C1 and C2 have been discharged from the program. Tenants #2, 3 and #4 have had service plan updates to reflect their current needs based on an accurate evaluation.

2. Service plans will be completed for all tenants to reflect their current needs on or before their admission, within 30 days of admission, at least annually and whenever changes are needed based on the evaluations conducted.
3. Tenant files will be audited periodically by the director or designee to determine compliance with developing service plans.
4. Date of compliance: March 11, 2026