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
	S0448	A. BUILDING: _____ B. WING _____	C 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLAND FARMS SENIOR LIVING	2800 SUNSET DRIVE NORWALK, IA 50211

(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: 47 Tenants with cognitive impairment: 7 Total census: 54 The following regulatory insufficiencies were cited during the investigation of Incident #131490-C.	A 000		
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 regarding Narrative Charting for 2 of 7 residents reviewed (Tenant #1 and Tenant #4). Findings follow: 1. Record review on 3/3/26 revealed a progress note dated 1/11/26 for Tenant #1 noted "resident returned from acute care..." Progress notes leading up to the 1/11/26 note failed to address the date/time or reason Tenant #1 had been sent to the hospital. Record review on 3/11/26 revealed a Medication Staff Communication Log dated 1/8/26, noted Tenant #1 "feeling unwell, advised to take some Advil" and then "sent to ER, left at 10pm."	A 150		

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A 150	Continued From page 1 2. Record review on 3/3/26 revealed a progress note dated 1/19/26 for Tenant #4 which noted "received update from social worker from the hospital for this resident ..." Progress notes leading up to the 1/19/26 note failed to address the date/time or reason Tenant #4 had been sent to the hospital. Record review on 3/11/26 revealed a Medication Staff Communication Log dated 1/15/26, noted Tenant #4 "sent to ER" and "Temp: 103.5, confused, weak, high temp, low oxygen. Family & (staff member) notified. Sent to Methodist DT." Record review on 3/10/26 revealed the Program's policy "Narrative Charting" dated 8/14/25 indicated narrative charting was maintained to promote clear communication regarding resident care. The policy indicated to chart to the exception. The policy directed the Health and Wellness Director or designee to chart significant information in the resident's record from the end of the shift report daily. During an interview on 3/11/26 at 3:30 p.m., the Executive Director acknowledged the Narrative Charting policy and confirmed the Medication Staff Communication Logs were used as a type of end of shift report and should have triggered a nurse or designee to complete a narrative charting entry related to being sent to the hospital for further evaluation/admission for Tenant #1 and Tenant #4. During exit on 3/1/26 at 4:00 p.m., the Executive Director and the Regional Nurse Consultant confirmed the above findings.	A 150		

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A 361	Continued From page 2	A 361		
A 361	481-67.9(4)f 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: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the Program failed to provide medication administration services in accordance with the competency training provided for 2 of 2 tenants reviewed (Tenant #1 and Tenant #7). Findings follow: Observations on 3/2/26 during the noon medication administration pass revealed the following: 1. Staff A began to initiate a medication pass for Tenant #1 for the tenant's Lactulose liquid and Novolog insulin injection. Staff A failed to wash/sanitize hands prior to beginning the medication administration services to the tenant. 2. Staff A began to initiate a medication pass for Tenant #7 for the tenant's Baclofen tablet and Novolog insulin injection. Staff A failed to wash/sanitize hands prior to beginning the medication administration services to the tenant. Record review on 3/11/26 revealed the Program's Competency Assessment form for Medication Administration included part of the preparation	A 361		

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A 361	Continued From page 3 step was to wash and dry hands thoroughly. Continued record review revealed the Program's Competency Assessment form for Sliding Scale Insulin Administration (pen) included part of the preparation step was to wash and dry hands thoroughly. During an interview on 3/11/26 at 3:30 p.m., the Executive Director acknowledged staff should wash their hands based on the competency assessments and staff not doing so failed to follow the training provided. During exit on 3/1/26 at 4:00 p.m., the Executive Director and the Regional Nurse Consultant confirmed the above findings.	A 361		