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
	S0449	A. BUILDING: ____ B. WING ____	C 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEADERS AT HOLLAND FARMS	**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 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: 4 Tenants with cognitive impairment: 33 Total census: 37 No regulatory insufficiencies were cited during the investigation of Incident #131478-I and Complaint #131438-C. The following regulatory insufficiencies were cited during the investigation of Complaints #130609-C, #131268-C, and #13150-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 policies regarding falls and incident reports for 1 of 11 tenants reviewed (Tenant #5). Findings follow: Record review on 3/4/26 revealed an incident report for Tenant #5, dated 1/20/26, noted a fall at 5:15 p.m. Program staff called and emergency medical services transported the tenant for further evaluation. The report was created/dated 1/23/26 at 12:32 p.m., three days after the incident. The incident report included a notation the family or representative of Tenant #5 was	A 150		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 150	Continued From page 1 contacted on 1/20/26 at 6:32 p.m., approximately one hour and 17 minutes after the incident. The incident report further noted Tenant #5's physician was notified on 1/23/26 at 12:50 p.m., three days after the incident. During an interview on 3/4/26 Staff C recalled the incident with Tenant #5. She indicated one of the Program nurses stated she would take care of completing the notifications. Staff C recalled the Program received a call from the hospital alerting them Tenant #5 had no family present at the hospital. They grew concerned the Program nurse had not completed any notification calls. Staff C reported the med tech then contacted Tenant #5's family. During an interview on 3/10/26 the Executive Director (ED) indicated he recalled the incident with Tenant #5 and the Med Techs assumed the clinical leadership team was going to complete the notifications, and the clinical leadership team assumed the med techs were going to complete them. The ED indicated it was his belief the clinical leadership team should have notified the parties. The ED believed the family was contacted the evening of the incident, just not as fast as he would have liked them to, but was unsure why the delay to contact the physician occurred and he would need to look into the matter. Review on 3/2/26 revealed the Program's policy, "Falls", dated 12/5/25, directed the Health and Wellness Director or designee to notify the resident's family and/or responsible party immediately, and provide information about the response to the resident's fall. Review on 3/4/26 revealed the Program's policy,	A 150		

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A 150	Continued From page 2 "Incident Reports" dated 8/14/25, indicated incidents were immediately reported to the resident's family and physician. During a follow-up interview on 3/11/26 at 3:30 p.m., the ED indicated the delay of notifying Tenant #5's family of an hour and 15 minutes after the incident, and a three-day delay of Tenant #5's physicians were both not considered "immediate" notification per the Program's policies. During exit on 3/11/26 at 4:00 p.m. the Executive Director and the Regional Nurse Consultant confirmed the above findings.	A 150		
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 #C1 and Tenant #11). Findings follow: 1. Observations on 3/2/26 during the noon medication administration revealed Staff B	A 361		

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A 361	Continued From page 3	A 361		

gathered an insulin pen, reviewed the label and compared it to Tenant #11's medication administration record. Staff B gloved without washing her hands. She approached the tenant in the dining room. Tenant #11 followed Staff B to the public bathroom. Tenant #11 exposed his belly and Staff B did not clean the area before the administration of the injection

2. During an interview on 3/4/26, Staff C acknowledged she once provided a syringe of Tenant #C1's morphine to Tenant #C1's daughter and allowed the tenant's daughter to administer the morphine medication (on an unknown date). Staff C stated "I know we can't do that", but indicated Tenant #C1's daughter would ask repeatedly for the pain medication. Staff C recalled she followed the daughter and was present as the daughter administered it, and then took the syringe back from the tenant's daughter after the administration.

Review on 3/11/26 revealed the Program's Competency Assessment form for Medication Administration included wash and dry hands thoroughly as a preparation step. The competency assessment included providing medications to the resident. The competency assessment did not indicate for staff to provide medications for family members of tenants to administer.

Continued record review revealed the Program's Competency Assessment form for Sliding Scale Insulin Administration (pen) included (but not limited to) the following steps:

a. Wash and dry hands thoroughly as part of the preparation.
b. Gather the insulin syringe and alcohol swabs.

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A 361	Continued From page 4 c. Wipe the top of the pen with alcohol to prepare the insulin pen. d. Clean the injection site with alcohol in a circular motion and allow it to dry before administering the insulin. During an interview on 3/11/26 at 3:30 p.m., the Executive Director acknowledged staff should wash their hands prior to Medication Administration services, use alcohol swabs on the tip of insulin injection pens and the injection site of tenants, and perform the actual administration of medications based on the Competency Assessments, if the tenant's service plan assigned responsibility to Program staff, and staff not doing so failed to follow the training provided by the Program. During exit on 3/11/26 at 4:00 p.m. the Executive Director and the Regional Nurse Consultant confirmed the above findings.	A 361		