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
	S0090	A. BUILDING: _____ B. WING _____	C 07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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: 0 Tenants with cognitive impairment: 13 Total census: 13 The following regulatory insufficiencies were cited related to the investigation of Complaint #131330-C and Incident #132131-I:	A 000	see attached POC 9/11/26	
A 116	481-67.2(2) Program Policies and Procedures 67.2(2) 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 and procedures related to falls, which pertained to 1 of 2 tenants reviewed who sustained a fracture (Tenant #1). Findings follow: 1. Record review on 6/25/26 and 7/6/26 of Tenant #1's file revealed an Incident Report Form dated 4/13/26 at 3:00 a.m. indicated Tenant #1 was found on the floor by staff when checks were completed. She complained of leg pain. There was no injury to her head. Tylenol was administered for pain. There was no bruising to her leg or hip area. It was noted "Just hurts when being stood up" and "put into bed." It was noted as a fall with injury. It was reported to a nurse (Staff C) on 4/14/26 (error in date) at 6:00 a.m., the primary care provider (PCP) on 4/14/26 (error	A 116		

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A 116	Continued From page 1	A 116		

in date) at 9:00 a.m. and Tenant #1's family on 4/14/26 (error in date) at 9:15 a.m. The Fall Flow Sheet indicated vitals were taken at 3:00 a.m. on 4/13/26 and at 8:00 a.m. on 4/13/26. At 8:00 a.m. it was noted observations changes from normal were indicated and "Left leg very painful with movement."

An attempt to interview Staff A was not successful.

Record review on 6/25/26 of Staff A's statement related to the incident indicated at 3:00 a.m. Tenant #1 was found on the floor next to her bed. Her walker was next to the end of her bed. She was dressed in pants and a tee-shirt. Tenant #1 was not incontinent and complained of leg pain. Staff administered Tylenol for pain. It also noted Tenant #1 had socks on.

When interviewed on 7/7/26 at 2:26 p.m. Staff B said worked with Staff A. It was a few days after Tenant #1 was admitted. Staff A and Staff B checked on her. The walker was positioned by her in case she got up and the lights were on in her bathroom. Tenant #1 was sitting up at her bedside. Staff A took vital signs (medication passer). Tenant #1 did not act like someone who had sustained an injury. Staff A asked her if she hit her head and was more concerned with that. Staff A and Staff B used a gait belt and got Tenant #1 up and put her into bed. Staff A asked her if she had any pain. Staff B said Tenant #1 always complained of pain in her legs and he did not know if she complained of pain later. Staff B said he did not think the Unit Director was notified. He did not know that Staff A had not notified the Unit Director. He was shocked she had not been notified.

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A 116	Continued From page 2 Continued record review of Staff B's statement indicated Staff B checked on Tenant #1 at 1:00 a.m., she was awake and in her bed. He assisted her with toileting and brought her back to bed. At 2:00 a.m. he checked on her and she was up and walking around her apartment. He assisted her back to bed. At 2:55 a.m. he checked on her again and found her on the floor and her walker also appeared to have fallen. Staff B went to get Staff A (medication passer). Staff A asked Tenant #1 if she was head was hurting and she said no. Staff A then asked if she had any kind of pain and Tenant #1 said no but "still insisted that she was in some kind of pain." Staff A took her vitals signs. Staff A and Staff B used the gait belt to assist Tenant #1 back up to bed. Staff A got a pain medication for her. Staff B continued to check on her every 30 to 40 minutes and she was asleep until staff left at 6:00 a.m. When interviewed on 7/6/26 at 9:36 a.m. Staff C said report had been given from third shift staff (Staff A and Staff B) that Tenant #1 had fallen, she was assisted up, denied pain and they put her back into bed. Staff went in to get Tenant #1 up that morning and she complained of leg pain and notified Staff C. Staff C went to assess her (not sure of the time). When Staff C went in Tenant #1 was lying in bed, her left leg/foot was hanging off of the bed. When asked what hurt Tenant #1 said her left leg. Vital signs were taken and were within normal limits. Staff C felt her leg and did not feel anything abnormal. When Tenant #1's leg was moved up, Staff C saw a deformity. A bulge was observed below the femoral head on her leg. Staff C notified the Unit Director and Staff C contacted the PCP's office and family. A portable x-ray was ordered and arrived within about 30 minutes. The decision was made to send Tenant #1 out to the hospital. There was	A 116		

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A 116	Continued From page 3	A 116		

notification it was fractured and she was admitted to the hospital. She said generally, the Unit Director or Staff C would be notified of falls. At night there was a medication passer. The Unit Director or Staff C assessed them if there was something to send a tenant out for. Staff C said she had not been contacted prior to her arrival.

When interviewed on 7/6/26 at 10:18 a.m. Staff D said she heard staff talk at shift report that Tenant #1 had fallen, nothing else was reported from third shift. She completed rounds at 6:20 a.m. or 6:30 a.m. and Tenant #1 was not ready and she had no complaints at that time. About 30 minutes later Staff D saw her leg hanging off of the bed and asked her if she could move it and she said yes. When Staff D moved it, Tenant #1 complained of pain. Staff D reported it to Staff C. Staff D was in the apartment when Staff C was looking and nothing was out of the ordinary.

When interviewed on 7/7/26 at 3:40 p.m. the Unit Director said Staff C had her come look at Tenant's #1. Her leg was hanging off of the bed, hanging to the floor. She was very painful. She told Staff C to get Tenant #1 something for pain and to get an x-ray. They would be there within 20 minutes, if it was longer she would have sent Tenant #1 out. Staff C called Tenant #1's family. Tenant #1 had a fractured femur. Tenant #1 had surgery, went to a nursing facility and returned. She said Staff A was asked why the Unit Manager was not notified and Staff A did not have a good answer. Staff A was asked to come in, she wrote her statement and she was terminated. Staff B wrote a statement and he was told anyone could call the Unit Director. Staff B did not know the Unit Manager had not been called. Staff B had checked on Tenant #1 about an hour and 10 minutes prior to the fall. Staff B found her on the

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A 116	Continued From page 4	A 116		

floor and called for Staff A. There was no notification of the Unit Manager, family or the PCP. Tenant #1 had been found on her side by the bathroom door. Staff B said there were no complaints of pain when Tenant #1 was assisted back to bed. The expectation was to call the Unit Director no matter what time of day and if there was a rash, skin tear or fall.

Record review on 6/25/26 of a Termination Notice indicated Staff A was terminated on 4/13/26 for violation of rules as the Unit Manager was not notified of tenant fall on 4/13/26 at 3:00 a.m. The tenant was sent out for evaluation and sustained a hip fracture.

Continued record review on 6/25/26 of an Employee Disciplinary Report dated 4/14/26 indicated Staff B received a final written warning for failure to notify management of a fall that occurred on 4/13/26 at 3:00 a.m. Tenant #1 was found on the floor in her apartment. Management was not notified of the fall and it resulted in a major injury.

Record review on 6/25/26 of Tenant #1's file revealed the admission summary dated 4/8/26 indicated she transferred from skilled nursing facility level of care and was an assist of one person with a walker for ambulation and transfers. The service plan in place at the time of the fall indicated for mobility, an assist of one with walker and hourly safety checks.

The April 2026 medication administration record (MAR) reflected an order for Tylenol oral tablet 325 milligram (mg), give 650 mg by mouth every 6 hours as needed for pain/fever. It was documented as administered on 4/13/26 by Staff A at 3:00 a.m. It was charted as "I" which was

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A 116	Continued From page 5 ineffective. Continued record review revealed Progress notes indicated the following: -On 4/13/26 it was noted Staff C was notified at shift change at 6:00 a.m. that Tenant #1 was found on the floor in her apartment at 3:00 a.m. She was back in bed and said it was better. Tylenol was administered per staff. Staff C was notified by staff getting her up that Tenant #1 complained of severe left upper leg pain. Staff C assessed her and she was laying on her back with her left leg handing on the side of the bed from the knee down. When Staff C attempted to move it, she cried out in pain. A lump was observed about 7 to 8 inches down from the hip joint on front of the thigh. The PCP was notified and agreeable to a portable x-ray. Tenant #1's family was notified. The result indicated a displaced fracture of the upper femur. Tenant #1 was transported to the hospital. -On 4/13/26 it was noted Tenant #1's family called and said Tenant #1 sustained left hip and femur fractures. She would be having surgery tomorrow. -On 6/4/26 it was noted Tenant #1 was re-admitted from a nursing facility. She ambulated with an assist of one from wheelchair to recliner with gait belt and walker. Further record review on 7/6/26 of hospital records indicated Tenant #1 was admitted on 4/13/26 and discharged on 4/20/26. Her principal diagnosis was displaced subtrochanteric fracture of the left femur. The records indicated she had an unwitnessed fall about 3:00 a.m. Throughout the day it was noted she was in continued pain	A 116		

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A 116	Continued From page 6 and swelling was noted. A mobile x-ray was completed and it showed a fracture. The family was notified at about 10:00 a.m. that she was complaining of discomfort and was not able to ambulate. Tenant #1 "underwent intramedullary femoral intertrochanteric nailing procedure on 4/14." Continued record review on 6/25/26 of the Program's Fall Policy indicated an incident report would be completed for all falls a neurological flow sheet would be started if a head injury was involved or if it was unwitnessed and a possible head strike. Tenants who had fallen should not be left alone. Staff was to use a walkie talkie or call light to call for help. The team lead or nurse would take vital signs, evaluate for injury, range of motion (ROM) check and neurological check. If no serious injury was noted to move the tenant to a comfortable position and complete an incident report. The family and on-call nurse would be contacted if not present. If the tenant reported any pain with ROM or serious injury staff was to call an ambulance to transport to the hospital and contact family and the nurse if not present.	A 116		
A 280	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with rule 481-69.22(231C) and be designed to meet the specific needs of the individual tenant. This REQUIREMENT is not met as evidenced by:	A 280		

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A 280	Continued From page 7 Based on interview and record review the Program failed to develop service plans that reflected the service needs of the tenants. This pertained to 3 of 4 tenants reviewed (Tenants #1, #3 and #4). Findings follow: 1. Record review on 6/25/26 and 7/7/26 of Tenant #1's file revealed weights indicated the following: -On 4/9/26 Tenant #1's weight was 165 pounds -On 6/5/26 Tenant #1's weight was 151.9 pounds When interviewed at the time of the exit interview on 7/8/26 at 11:00 a.m. the Unit Director said Tenant #1 was weighed on 7/8/26 and her weight was 144 pounds. (12.72 % body weight loss) Continued record reviewed revealed Progress Notes indicated Tenant #1 was sent to the hospital on 4/13/26, was admitted and went to a nursing facility. She returned to the Program on 6/4/26. Further record review revealed Tenant #1's service plan did not reflect the weight loss or interventions. 2. Record review on 7/7/26 of Tenant #3's file revealed weights indicated the following: -On 1/21/26 Tenant #3's weight was 136.4 pounds -On 5/7/26 Tenant #3's weight was 129 pounds -On 6/4/26 Tenant #3's weight was 126.4 pounds	A 280		

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A 280	Continued From page 8 (7.33 % body weight loss) Continued record review revealed Tenant #3's service plan revealed she enjoyed healthy snacks and did not often sit for a complete meal and to provide finger foods if it occurred. Tenant #3's service plan did not reflect Tenant #3's weight loss and any additional interventions. 3. Record review on 7/7/26 of Tenant #4's file revealed on 6/15/26 at 9:00 p.m. staff responded to the door alarm (door #4) and observed Tenant #4 in the parking lot. Tenant #4 was easily redirected inside. The electronic wandering monitoring device was on and functioned. No injuries were noted. Tenant #4 said he wanted to go places. Trazodone and acetaminophen were administered as needed. Continued record review revealed a screen shot dated on 6/16/26 in the category of behavior management (individualized service plan category) indicated a task was created that indicated to monitor exit seeking behaviors, wandering down the opposite hallway from his apartment, comment about leaving or having his coat on. Staff to redirect him and respond to door alarms immediately. Further record review revealed Tenant #4's service plan indicated he was an elopement risk; however, did not reflect he had eloped from the building. 4. When interviewed on 7/8/26 at 9:53 a.m. the Unit Director confirmed the service plan for Tenant #4 did not reflect he had left the building. Regarding weight loss for Tenant #3 she attributed to it reliability issues with the scale.	A 280		

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A 280	Continued From page 9 She confirmed weight loss was not on the service plan for Tenant #1.	A 280		

Hiawatha Care Center

405 N 15th Avenue · Hiawatha, Iowa 52233
Business Office: 319-378-8583 Fax: 319-378-8598
Email: hccinfo@hiawathacarecenter.com

September 11, 2026

Iowa Department of Inspections, Appeals, and Licensing
6200 Park Avenue, Suite 100
Des Moines, Iowa 50321

RE: Plan of Correction – Promise House, Hiawatha
Survey Dates: June 25–July 8, 2026

To Whom It May Concern:
On behalf of Promise House in Hiawatha, I respectfully submit the following Plan of Correction in response to the statement of insufficiencies resulting from the survey conducted June 25 through July 8, 2026. Preparation and/or implementation of this Plan of Correction does not constitute an admission or agreement by the provider as to the truth of the alleged facts or conclusions set forth in the statement of insufficiencies. This Plan of Correction is submitted solely as required by Iowa law. Promise House does not intend to appeal.

Program Policies and Procedures

1. Corrective action taken for the identified insufficiency
- The facility will follow its Incident Reporting and Fall with Potential Head Injury policies and procedures.
- Staff will notify the nurse prior to assisting a tenant from the floor when an injury is observed or the tenant exhibits signs of pain or discomfort.

2. Measures taken to ensure the problem does not recur
- The RN and nurse designee(s) will retrain staff on policies and procedures related to incident reporting and falls, including the requirement to notify nursing prior to assisting a tenant from the floor when injury or discomfort is observed. Education was completed on April 15, 2026 following the event and again on September 11, 2026.

3. Monitoring to ensure continued compliance
- The Director or designee will review processes associated with reported incidents on an ongoing basis and will formally review incident tracking and trending at least quarterly to verify continued compliance with facility policy and procedures.

4. Date the regulatory insufficiency was corrected
- Corrective action and staff education were completed on September 11, 2026, with ongoing monitoring as described above.

Service Plans

1. Corrective action taken for the identified insufficiency

- Tenant service plans will reflect identified needs and preferences and will be updated as changes in condition, risks, or needs are identified.
- When weight loss is identified, the tenant's service plan will address the identified concern and include appropriate interventions intended to minimize further weight loss.
- For tenants exhibiting exit-seeking or elopement behavior, the service plan will identify the risk and include individualized interventions based on the tenant's assessed needs and behaviors.

2. Measures taken to ensure the problem does not recur

- The RN and nurse designee(s) were re-educated regarding regulatory requirements for service plans through policy review and re-education.
- The RN and nurse designee(s) were re-educated to review and update service plans following exit-seeking or elopement incidents and to implement additional or revised interventions as indicated by the tenant's needs and behaviors.

3. Monitoring to ensure continued compliance

- The Director or designee will review tenant records to verify that service plans accurately reflect identified needs, risks, preferences, and interventions. Reviews will occur at least annually and additionally when a change in condition, incident, or other identified concern indicates that the service plan should be reviewed or revised.

4. Date the regulatory insufficiency was corrected

- The corrective actions described above were completed as of September 11, 2026. Ongoing monitoring will continue as described above.

Promise House is committed to maintaining compliance with applicable Assisted Living Program and ensuring that the corrective actions outlined in this Plan of Correction are implemented and sustained. The facility will continue to monitor compliance and take additional corrective action as necessary.

Please contact us if additional information or documentation is needed regarding this Plan of Correction.

Sincerely,

Gina Wendel, Director

Miranda Barnhart, Administrator