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
	S0083	A. BUILDING: _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE VALLEY PLACE	801 BLUNT PKWY #39 CHARLES CITY, IA 50616

(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. Number of tenants without cognitive impairment: 21 Number of tenants with cognitive impairment: 6 Total census: 27 No regulatory insufficiencies were cited during the investigation of #124386-I, #125060-C, #126972-C or #127294-C. The following regulatory insufficiencies were cited during the investigation of #127456-M, #127330-C and #127399-C.	A 000	The Plan of Correction is attached	
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure lab orders were completed as ordered and medications were	A 285		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 285	Continued From page 1	A 285		

administered as prescribed for 1 of 3 tenants reviewed (Tenant 3). Findings follow:

1) Record review on 4/10/25 revealed Tenant 3 admitted to the program on 7/31/24. An assessment dated 1/13/25 as well as a service plan dated 2/3/25 both revealed the tenant required monthly lab draws managed by the program's nurse and drawn by an outside provider. Program staff were responsible for providing medication administration.

2) A faxed communication dated 3/20/25 from the tenant's medical clinic revealed Tenant 3 was ordered to have a lab drawn for a Prothrombin Time (PT)/International Normalized Ratio (INR), hence after (PT/INR) as no lab had been drawn since 12/24.

A progress note dated 1/3/25 indicated the lab results were received and the program was instructed to recheck the INR in a month.

A lab draw was completed on 1/14/25 but did not include the PT/INR.

A lab draw was completed on 3/20/25 per the faxed communication from the tenant's medical clinic.

A faxed communication dated 3/21/25 from the medical clinic noted the INR results as 2.0 and instructed the program to continue Warfarin medication as follows: 2.5mg Sunday, Tuesday, Wednesday, Friday, and Saturday; 3mg Monday and Thursday. The INR was to be rechecked in one month. A program progress note dated 3/21/25 confirmed receipt of the communication and updated orders.

The Executive Director stated on 4/14/25 at 1:10 pm that no documentation could be located regarding PT/INR labs having been completed during the months of January and February of

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A 285	Continued From page 2 2025. 3) Review of Tenant 3's Medication Administration Records (MARs) for March 2025 and April 2025 listed 2.5mg of Warfarin to be administered at 9:00 pm on Sundays, Tuesdays, Wednesdays, Fridays, and Saturdays. There were 2 days in March (3/13/25 and 3/20/25) where it was documented the tenant received both the 2.5mg and the 3mg doses of Warfarin (3/15/25 and 3/16/25), both times administered by different staff. The 2.5mg dose was documented as not available to administer on 3/15/25 and 3/16/25. The 3mg dosage was documented as unavailable on 3/24/25 and 3/27/25. The April 2025 MAR revealed staff documented Tenant 3 received the 2.5mg Warfarin daily (except for Thursday 4/3/25 when she received 3 mg as ordered) instead of the ordered schedule of 3mg Warfarin on Mondays and Thursdays. 4) The Executive Director stated on 4/14/25 at 1:10 pm that the administration of the Warfarin was not completed as ordered but would be corrected. On 4/15/25 at 3:30 pm the Executive Director, Regional Director of Operations, and Chief Financial Officer confirmed the above findings.	A 285		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16.	A 380		

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A 380	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure 1 of 1 staff reviewed completed dependent adult abuse training as required by Iowa Code section 235B.16 (Staff A). Findings follow: Chapter 235B.16 requires employees complete two hours of training related to the identification and reporting of dependent adult abuse within six months of initial employment and at least 2 hours of additional training every three years. Review of Staff A's employment file on 4/8/25 revealed a hire date of 8/26/24. No dependent adult training completed after her hire date could be located. On 4/10/25, the program provided documentation of a previous training Staff A had completed on 2/19/21, however since the training is required every three years, it had expired prior to the employee's hire date with the program. During an interview on 4/9/25 at 2:30 pm with Staff A, she confirmed she had not completed dependent adult abuse training after being hired at the program. On 4/15/25 at 3:30 pm the Executive Director, Regional Director of Operations, and Chief Financial Officer confirmed the above findings.	A 380		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either	A 545		

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A 545	Continued From page 4 employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure staff received a minimum of eight hours of dementia-specific education within 30 days of employment for 1 of 1 staff reviewed (Staff A.) Findings follow: Review of Staff A's employment file on 4/8/2025 revealed a hire date of 8/26/24. On 4/10/25, the program provided documentation that Staff A completed 1.0 hours of dementia-specific training within 30 days of employment. The Executive Director stated on 4/14/25 at 1:10 pm that no other dementia-specific training could be located. On 4/15/25 at 3:30 pm the Executive Director, Regional Director of Operations, and Chief Financial Officer confirmed the above findings.	A 545		

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CLIA ID # S0083 **Survey Completion Date 4/15/2025**

Prefix Tag	Plan of Correction
A285	Instant in-service provided to medication managers specific to medication administration, including the 6 Rights of Safe Medication Administration: Implementation and Completion - 4/17/2025 AJ, BSN RN Education provided to community nurse to verify orders from physician match orders entered into EHR system. Implementation and Completion – 4/17/2025 KH, BSN RN
A380	Employee file audit to ensure all current staff members have completed and are up to date with Dependent Adult Abuse training. Implementation – 4/18/2025 Completion – 4/30/2025 CB, Executive Director Executive Director to create and maintain a staff spreadsheet to ensure, and verify, required training to be completed in a timely manner, within 30 days of hire. Implementation – 4/18/2025 Completion – 5/5/2025 CB, Executive Director

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A545 Employee file audit to ensure all current staff members have completed and are up to date with Dementia-specific training.

Implementation – 4/18/2025
Completion – 4/30/2025
CB, Executive Director

Executive Director to create and maintain a staff spreadsheet to ensure, and verify, required training to be completed in a timely manner, within 30 days of hire.

Implementation – 4/18/2025
Completion – 5/5/2025
CB, Executive Director