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 |
|---|---|---|---|
| | S0092 | A. BUILDING: _____ B. WING _____ | C 04/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE PATH AT THE KENSINGTON | 2210 AVE H FORT MADISON, IA 52627 |

| (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<br><br>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.<br><br>Number of tenants without cognitive impairment: 0<br>Number of tenants with cognitive impairment: 18<br>Total census: 18<br><br>No regulatory insufficiencies were cited during the investigation of Complaints #125685-C, 127598-C, 127599-C and 127600-C.<br><br>The following regulatory insufficiencies were cited during the investigation of Complaints #124351-A, #126492-A and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia. | A 000 | | |
| A 105 | 481-67.2 Program Policies and Procedures<br><br>481-67.2 Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.<br><br>This REQUIREMENT is not met as evidenced | A 105 | The Plan of Correction is attached. | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | S0092 | A. BUILDING: _____ B. WING _____ | C 04/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE PATH AT THE KENSINGTON | 2210 AVE H FORT MADISON, IA 52627 |

| (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 105 | Continued From page 1<br>by:<br>Based on interview and record review, the program's policy on dependent adult abuse failed to meet the minimum standards as set forth in Chapter 235E. Findings follow:<br><br>Record review on 4/8/25 revealed the program had an Abuse, Neglect and/or Exploitation policy dated 9/12/24. The policy failed to include Personal Degradation as a type of dependent adult abuse as found in 235E.1(5)(a)(3).<br><br>In addition, the policy failed to include the requirement for a staff person or the person in charge who is aware of abuse to notify the department within twenty-four hours of such notification as found in 235E.2(3)(a)<br><br>The Executive Director confirmed the Abuse, Neglect and/or Exploitation policy failed to meet the minimum standards on 4/9/25 at 10:15 AM. | A 105 | | |
| A 150 | 481-67.2(3) Program Policies and Procedures<br><br>67.2(3) The program shall follow the policies and procedures established by the program.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the program failed to follow the policy on Abuse, Neglect and Exploitation regarding 1 of 2 tenants reviewed for dependent adult abuse (Tenant #5). Findings follow:<br><br>1) Record review on 4/2/25 revealed Tenant #5 was diagnosed with dementia, lower back pain | A 150 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | S0092 | A. BUILDING: _____ B. WING _____ | C 04/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE PATH AT THE KENSINGTON | 2210 AVE H FORT MADISON, IA 52627 |

| (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 150 | Continued From page 2 | A 150 | | |

and an unsteady gait. Her service plan dated 3/12/25 noted she scored a 6 on the Global Deterioration Scale indicating a severe cognitive decline. She had trouble with word-finding due to her dementia. She required monitoring and cuing to meet her communication needs.

2) On 4/7/25 at 1:15 PM Staff B stated Tenant #5 had a hard time communicating and Staff C thought it was funny when the tenant would make sounds and wave her hands in the air, so she would agitate her to make this happen. Staff C also got a rise out of Tenant #5 by removing her wig without her permission. This first happened when Staff B was in training with Staff C in 2023 and continued during the time they worked together. She heard from other employees Staff C was still removing Tenant #5's wig as a way to tease her. About once a week Staff C would get Tenant #5 so aggravated the tenant hit her with a cane. Staff B reported her concerns with Staff C to the Director of Nursing (DON) when she was first hired and was told she needed to get a video of Staff C's actions in order for her to take action. She believed Staff C's actions were abusive, but thought since there was no proof, nothing could be done.

On 4/7/25 at 2:25 PM Staff A reported she had seen Staff C mock Tenant #5 when she made sounds, which would make Tenant #5 upset. Staff A indicated Tenant #5 would wave her hands and vocalize like a gorilla and Staff C did this back, which agitated the tenant. When helping Tenant #5 get ready for bed, Staff A would ask her if she wanted to remove her wig. Staff C would remove Tenant #5's wig without asking if it was okay and the tenant would say, no, no, no and wave her hands because she wanted to keep it on. Staff A had also seen Tenant #5 swing her cane in Staff

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | S0092 | A. BUILDING: _____ B. WING _____ | C 04/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE PATH AT THE KENSINGTON | 2210 AVE H FORT MADISON, IA 52627 |

| (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 150 | Continued From page 3 | A 150 | | |

C's direction, indicating she wanted to be left alone. Tenant #5 tapped her cane on the ground when Staff A was around, but never tried to hit her with it. Staff A noticed Staff C would "keep at" tenants when they indicated they did not want to do something rather than leave them alone. Staff A received dependent adult abuse training and knew what Staff C was doing wasn't right, but did not tell management about what she did for fear she would not be believed or action would not be taken.

On 4/7/25 at 4:10 PM Staff D expressed concern about the way Staff A and Staff C treated Tenant #5. Staff A and Staff C took the tenant's cane after she hit Staff A with the cane a number of times. Staff D did not think Tenant #5 should be treated in this manner and believed their actions seemed abusive.

On 4/7/25 at 3:00 PM Staff E said he heard about Staff C messing with Tenant #5's wig. Tenant #5 spoke to tenants in a manner he did not think she should. He thought Staff C should work somewhere else if she was going to treat tenants poorly.

On 4/2/25 at 9:50 AM Staff F reported she heard Staff B and Staff C took Tenant #5's wig without her permission, but had not seen this herself.

3) The program had a policy on Abuse, Neglect and/or Exploitation, dated 9/12/24, which included verbal abuse, mental abuse and cruel punishment. The program was committed to providing a safe environment for all tenants within the state-specific regulations and WOULD NOT TOLERATE abuse. All employees had the responsibility to report abuse to the proper authorities, including the Iowa Department of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | S0092 | A. BUILDING: _____ B. WING _____ | C 04/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE PATH AT THE KENSINGTON | 2210 AVE H FORT MADISON, IA 52627 |

| (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 150 | Continued From page 4<br>Inspections, Appeals and Licensing. When abuse was suspected, the Director or nurse would be notified immediately.<br><br>Five staff were aware of concerning treatment of Tenant #5. Staff B stated she reported it one time to the DON but was told she needed to get a videotape of the mistreatment before anything could be done. The four other staff did not report the treatment of Tenant #5 to the Executive Director, DON or the Department as indicated in the Abuse, Neglect and/or Exploitation policy.<br><br>4) On 4/8/25 at 2:30 PM the Executive Director, DON and Memory Care Manager denied knowledge of anyone mistreating Tenant #5. The DON denied receiving any text messages from Staff B about Staff C removing the tenant's wig | A 150 | | |
| A 155 | 481-67.3(1) Tenant Rights<br><br>481-67.3 Tenant rights. All tenants have the following rights:<br><br>67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the program failed to ensure 2 of 6 tenants reviewed were treated with respect and dignity (Tenant #2 and Tenant #5). Findings follow:<br><br>1) Record review on 4/2/25 revealed Tenant #5 was diagnosed with dementia, lower back pain | A 155 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | S0092 | A. BUILDING: _____ B. WING _____ | C 04/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE PATH AT THE KENSINGTON | 2210 AVE H FORT MADISON, IA 52627 |

| (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 155 | Continued From page 5 | A 155 | | |

and an unsteady gait. Her service plan dated 3/12/25 noted she scored a 6 on the Global Deterioration Scale indicating a severe cognitive decline. She had trouble with word-finding due to her dementia. She required monitoring and cuing to meet her communication needs.

On 4/7/25 at 1:15 PM Staff B stated Tenant #5 had a hard time communicating and Staff C thought it was funny when the tenant would make sounds and wave her hands in the air, so she would agitate her to make this happen. Staff C also got a rise out of Tenant #5 by removing her wig without her permission. This first happened when Staff B was in training with Staff C in 2023 and continued during the time they worked together. She heard from other employees Staff C was still removing Tenant #5's wig as a way to tease her. About once a week Staff C would get Tenant #5 so aggravated the tenant hit her with a cane. Staff B reported her concerns with Staff C to the Director of Nursing (DON) when she was first hired and was told she needed to get a video of Staff C's actions in order for her to take action. She believed Staff C's actions were abusive, but thought since there was no proof, nothing could be done.

On 4/7/25 at 2:25 PM Staff A reported she had seen Staff C mock Tenant #5 when she made sounds, which made Tenant #5 upset. Staff A indicated Tenant #5 would wave her hands and vocalize like a gorilla and Staff C did this back, which agitated the tenant. When helping Tenant #5 get ready for bed, Staff A would ask her if she wanted to remove her wig. Staff C would remove Tenant #5's wig without asking if it was okay and the tenant would say, no, no, no and wave her hands because she wanted to keep it on. Staff A had also seen Tenant #5 swing her cane in Staff

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | S0092 | A. BUILDING: _____ B. WING _____ | C 04/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE PATH AT THE KENSINGTON | 2210 AVE H FORT MADISON, IA 52627 |

| (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 155 | Continued From page 6 | A 155 | | |

C's direction, indicating she wanted to be left alone. Tenant #5 tapped her cane on the ground when Staff A was around, but never tried to hit her with it. Staff A noticed Staff C would "keep at" tenants when they indicated they did not want to do something rather than leave them alone. Staff A received dependent adult abuse training and knew what Staff C was doing wasn't right, but did not tell management about what she did for fear she would not be believed or action would not be taken.

On 4/7/25 at 4:10 PM Staff D expressed concern about the way Staff A and Staff C treated Tenant #5. Staff A and Staff C took the tenant's cane after she hit Staff A with the cane a number of times. Staff D did not think Tenant #5 should be treated in this manner and believed their actions seemed abusive.

On 4/7/25 at 3:00 PM Staff E said he heard about Staff C messing with Tenant #5's wig. Tenant #5 spoke to tenants in a manner he did not think she should. He thought Staff C should work somewhere else if she was going to treat tenants poorly.

On 4/2/25 at 9:50 AM Staff F reported she heard Staff B and Staff C took Tenant #5's wig without her permission, but had not seen this herself.

2) Review of Tenant #2's face sheet on 4/2/25 revealed she was diagnosed with a history of transient ischemic attack, or mini-stroke, and dementia. Her 3/27/25 service plan identified she scored 5 on the Global Deterioration Scale, indicating a moderately severe cognitive decline.

On 4/2/25 at 12:20 PM, the Memory Care Manager recalled seeing a video which Staff A

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | S0092 | A. BUILDING: _____ B. WING _____ | C 04/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE PATH AT THE KENSINGTON | 2210 AVE H FORT MADISON, IA 52627 |

| (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 155 | Continued From page 7 | A 155 | | |

posted on the social media site, Snapchat. This occurred about six months ago. She couldn't remember what was posted clearly but thought she saw Tenant #2 sitting at a table talking about putting something up her [rectum]. It was clearly Staff A's Snapchat account and visible publicly to others on Snapchat. The Memory Care Manager believed as a Certified Nursing Aide, Staff A should have known better than to post such a thing on the internet. She believed the video was posted to make fun of Tenant #2 and displayed information which should not have been known outside of the building. She did not want Staff A working with tenants on the memory care unit after this, but the Executive Director stated she should be given a second chance.

On 4/2/25 at 10:30 AM, Staff B stated she saw a video posted on Snapchat in which Tenant #2 was sitting at a table in her pajamas speaking with Staff A. Tenant #2 said she put her bratwurst up her [rectum] after supper so she could save it for later. Staff A and Tenant #2 were laughing. Staff B told her a couple of different stories about how the video ended up on Snapchat, such as her son (who was 18 months old) posted the video; and she meant to send it to another co-worker but it ended up on social media.

On 4/2/25 at 12:51 PM the Director of Nursing (DON) reported she found the Snapchat video to be disrespectful and disgusting. She believed Staff A found the video to be humorous when she posted it on Snapchat, but the DON would have been devastated if her loved one was on the video.

Interviews conducted with the Executive Director on 4/2/25, 4/3/25 and 4/8/25 revealed she was not present when staff learned of the video and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | S0092 | A. BUILDING: _____ B. WING _____ | C 04/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE PATH AT THE KENSINGTON | 2210 AVE H FORT MADISON, IA 52627 |

| (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 155 | Continued From page 8<br>did not see it herself. She met with Staff A and the Memory Care Manager about the posting of a video shaming a tenant on social media. Staff A crumpled up the paper on which the disciplinary notice was written. The Executive Director did not retain the notice and could not find a copy on her computer. There were no consequences to Staff A for putting the video of Tenant #2 on Snapchat. The Executive Director stated she was not aware posting a degrading video of a tenant on social media could be dependent adult abuse and if the situation arose again, she would likely handle it in the same manner.<br><br>3) Program staff were aware of two tenants being treated without respect or given the dignity they deserved. Five staff reported being aware Staff C teased, agitated and spoke to Tenant #5 in a manner which was unacceptable. This treatment was allowed to continue for over a year. Staff A posted a demeaning video of Tenant #2 to social media.<br><br>On 4/8/25 at 2:30 PM the Executive Director, DON and Memory Care Manager denied knowledge of anyone mistreating Tenant #5. The DON had not received any text messages from Staff B about Staff C removing the tenant's wig. They agreed staff failed to protect the rights of Tenants #2 and #5 | A 155 | | |
| A 355 | 481-69.26(2) Service Plans<br><br>69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other | A 355 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | S0092 | A. BUILDING: _____ B. WING _____ | C 04/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRIMROSE PATH AT THE KENSINGTON | 2210 AVE H FORT MADISON, IA 52627 |

| (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 355 | Continued From page 9<br>individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the program failed to ensure occupancy agreements and/or service plans were signed prior to taking occupancy by the legal representative of 2 of 3 tenants admitted within the prior 2 months (Tenant #1 and Tenant #4). Findings follow:<br><br>Record review on 4/3/25 revealed Tenant #1 moved to the program on 2/4/25. Tenant #1's legal representative did not sign the occupancy agreement until 2/6/25. The initial service plan was signed by her legal representative on 2/4/25.<br><br>Tenant #4 moved to the program on 3/20/25. His legal representative did not sign the occupancy agreement or initial service plan until 4/4/25.<br><br>The Executive Director confirmed the program failed to ensure tenants' legal representatives reviewed and signed the occupancy agreements and/or service plan prior to moving into the program. | A 355 | | |

Plan of Correction

Primrose Path at the Kensington

2210 Avenue H Fort Madison, IA 52627

May 7, 2025

A105 481.67.2 Program Policies and Procedures

The Kensington has passed on to our corporate nurse that our policy did not met standards and our Dependent adult abuse policy is being re-written. This will be complete and sent over by May 9, 2025 and shared with all staff members by the Executive Director.

A150 481-67.2(3) Program Policies and Procedures

The Executive Director and the DON have talked with all staff about any form of abuse needs to be reported to the ED, DON, or Memory Care Manager at all times. The Executive director and HR Assistant will ensure that all new staff will review this form, sign, and put in their file up hire. We will monitor performance on this by reviewing it quarterly at staff meetings. On April 18, 2025 all staff signed documentation that they are aware they are mandatory reporters and that any form of abuse must be communicated to management.

A155 481-67.3(1) Tenant Rights

The Executive Director and the DON are responsible for ensuring that all tenants are treated with dignity. All new staff are given a copy of tenant rights upon hire that the Executive Director or HR Assistant will go over with them and sign upon hire. The program will touch base and train on tenant rights quarterly at staff meetings. All current staff have been given a copy of tenant rights and the expectations again on April 18,2025. This is also located in the employee handbook but all new hires are given a copy to sign as well.

A355 481-69.26(2) Service Plans

The Executive Director and the DON will work together to ensure that all service plans and occupancy agreements are signed prior to taking occupancy. The HR assistant will ensure that all documents are signed when filing and will audit files monthly to ensure they are signed. This occurred in our building moving from AL to MC and we both will ensure this is done moving forward. This has been completed as of April 15, 2025.

√ 5/19/25