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
	S0208	A. BUILDING: _____ B. WING _____	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF MT PLEASANT	1406 EAST LINDEN DRIVE MOUNT PLEASANT, IA 52641

(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: 39 Tenants with cognitive impairment: 8 Total census: 47 The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with licensing rules for an Assisted Living Program for People with Dementia.	A 000		
A 282	481-69.26(3) Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. The service plan shall be signed by all parties, including the tenant or tenant's legal representative. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update the service plan within 30 days for 1 of 1 tenants reviewed who was admitted in the previous 90 days (Tenant #1). Findings follow: Record review on 5/4/26 revealed Tenant #1 moved to the Program on 2/4/26. The Program	A 282		

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

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
	S0208	A. BUILDING: _____ B. WING _____	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF MT PLEASANT	1406 EAST LINDEN DRIVE MOUNT PLEASANT, IA 52641

(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 282	Continued From page 1 nurse developed an initial service plan on 2/4/26. Tenant #1 did not have an additional service plan within 30 days. During an interview with the Executive Director on 5/4/26 at 4:20 PM she confirmed the Program failed to write a 30-day service plan for Tenant #1.	A 282		