STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0259	A. BUILDING: _____ B. WING _____	C 10/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF OTTUMWA	173 EAST ROCHESTER STREET OTTUMWA, IA 52501

(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 type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 18 Number of tenants with cognitive disorder: 1 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 5 TOTAL census of Assisted Living Program for People with Dementia: 24 The following regulatory insufficiencies were cited during the investigation of Complaints #101853-C, #102323-C, #104971-C, #104803-C, #106549-C.	A 000	See Attached POC 1/3/23	
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 observation, interview, and record review the Program failed to follow it's policy for COVID-19 precautions. This potentially affected all 24 tenants. Findings follow: On 10/4/22 at 9:00 a.m. the entrance door had a sign noting masks were required. Staff A failed to wear a mask when she greeted this surveyor at the door. Further observations of the noon meal	A 150		

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A 150	Continued From page 1 revealed Staff C served meals to tenants in the dining room with her mask below her nose and/or mouth. Staff D dished up the food on plates and wore her mask below her nose. Around 3:00 p.m. Staff B worked in the memory care unit and had her mask below her chin with 2 tenants within six feet of her. On 10/5/22 during the noon meal Staff D walked the hot cart of food to the memory care unit and failed to have on a mask. Staff C served meals to tenants in the dining room with her mask below her nose and mouth. Record reveiw on 10/4/22 of the Program's COVID-19 education outlined transmission precautions and included the staff were to wear a mask at all times. On 10/4/22 Staff A laughed and said they were boycotting them when asked why she failed to wear a mask as required. She then put one on. On 10/5/22 at 11:47 a.m. Staff C confirmed staff were required to wear masks. She stated she forgot to put it over her nose as it gets hot at times. On 10/5/22 at 11:49 a.m. Staff D stated she forgot to put a mask on when she took the food cart to the memory care unit. She acknowledged staff were required to wear them. On 10/11/22 at 3:00 p.m. the Director confirmed these findings.	A 150		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written	A 285		

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A 285	Continued From page 2 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 provide medical treatments as ordered by a physician. This pertained to 1 of 1 tenants that required International Normalized Ration (INR) checks for blood thinners (Tenant C3). Findings follow: Record review on 10/5/22 of Tenant C3's physician's orders dated 11/3/22 revealed an order for daily INR (measurement of time for blood to clot). No record of daily INR checks could be located. On 10/6/22 the Regional Director of Sales and Operations confirmed these findings.	A 285		
A 325	481-67.9(1) Staffing 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 325		

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A 325	Continued From page 3	A 325		

Program failed to have a sufficient number of staff available to meet the identified needs of the tenants in the memory care unit. This pertained to 1 of 1 current tenants (Tenant #1) and 1 of 1 discharged tenants (Tenant C2) requiring safety checks every 15 minutes and potentially affected all tenants in the memory care unit. Findings follow:

1. Record review on 10/6/22 of Tenant #1's file revealed the following:

a. Progress Notes documented two elopements and six incidents of physical aggression, verbal, and/or sexual behaviors toward staff and/or tenants from 4/10/22 to 5/23/22. On 4/2/22 he was sent to the hospital for treatment of his behavior. Continued review of notes from 7/25/22 to 8/24/22 revealed two incidents of urinating in the hallway, two elopement attempts, and five incidents of physical/sexual aggression. On 8/24/22 he was sent to the emergency room for physical aggression towards staff.

b. The Service Plan, dated 5/18/22, revealed he was a high risk for elopement due to attempts at previous facility and required safety checks 32 times per shift.

On 10/3/22 at 12:51 p.m. Staff E stated Tenant #1 displayed physical, verbal, and/or sexual behavior and was hard to manage with only one staff in the memory care unit. She confirmed he required 15 minute checks and stated staff could not do this and take care of the other tenants.

On 10/6/22 at 1:17 p.m. Staff F confirmed Tenant #1 required 15 minutes checks due to behavior. She stated he attempted to leave the memory care unit several times and succeeded in the

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	S0259	A. BUILDING: _____ B. WING _____	C 10/11/2022

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A 325	Continued From page 4 leaving the unit a few times but remained in the building. She said it was very difficult to provide care to the other tenants in the memory care with only one staff. She reported she discussed this with the previous nurse several times and she would only call his physician for med changes. 2. Record review on 10/6/22 of Tenant C2's file revealed the following: a. Incident by Incidents by Incident Type report listed six witnessed and 40 unwitnessed fall between 3/19/22 and 7/5/22. b. Service Plan dated 5/12/22 revealed she required safety checks every 15 minutes for falls. c. Review of staff schedules from May 2022 through September 2022 revealed 3 staff scheduled from 6:00 a.m. to 8:00 p.m. and two staff scheduled from 8:00 p.m. to 6:00 a.m. On 10/6/22 at 11:34 a.m. the Regional Director of Sales and Operations confirmed it would have been very difficult for one staff to manage 15 minute checks and provide appropriate care to the other tenants in the memory care unit. On 10/11/22 at 3:00 p.m. the Director confirmed these findings.	A 325		
A 160	481-69.23(1)c(1) Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who:	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0259	A. BUILDING: _____ B. WING _____	C 10/11/2022

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A 160	Continued From page 5 c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to discharged tenants who chronically displayed unmanageable elopement and verbal and physically abusive behaviors. This pertained to 1 of 1 tenants with history of elopement and aggressive behavior (Tenant #1). Findings follow: Record review on 10/6/22 of Tenant #1 file revealed the following: 1. Progress Notes documented two elopements and six incidents of physical aggression, verbal, and/or sexual behaviors toward staff and/or tenants from 4/10/22 to 5/23/22. On 4/2/22 he was sent to the hospital for treatment of his behavior. Continued review of notes from 7/25/22 to 8/24/22 revealed two incidents of urinating in the hallway, two elopement attempts, and five incidents of physical/sexual aggression. On 8/24/22 he was sent to the emergency room for physical aggression towards staff. 2. The Service Plan dated 5/18/22 revealed he was a high risk for elopement due to attempts at previous facility and required safety checks 32 times per shift. On 10/3/22 at 12:51 p.m. Staff E stated Tenant #1 displayed physical, verbal, and/or sexual behavior and was hard to manage with only one staff in the	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 160	Continued From page 6 memory care unit. She confirmed he required 15 minute checks and stated staff could not do this and take care of the other tenants. On 10/6/22 at 1:17 p.m. Staff F confirmed Tenant #1 required 15 minutes checks due to behavior. She stated he attempted to leave the memory care unit several times and succeeded in the leaving the unit a few times but remained in the building. She said it was very difficult to provide care to the other tenants in the memory care with only one staff. She reported she discussed this with the previous nurse several times and she would only call his physician for med changes. On 10/6/22 at 11:34 a.m. the Regional Director of Sales and Operations confirmed it would have been very difficult for one staff to manage 15 minute checks and provide appropriate care to the other tenants in the memory care unit.	A 160		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans based on the required evaluations to meet the specific needs for 1 of 2 discharged tenants reviewed with	A 350		

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	S0259	A. BUILDING: _____ B. WING _____	C 10/11/2022

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A 350	Continued From page 7 hospice care (Tenant C1). Findings follow: Record review on 10/4/22 of Tenant C1's Comprehensive Assessment completed 5/3/22 noted admission to hospice care following a hospital stay. Progress Notes dated 5/3/22 documented she returned from the hospital with a Foley catheter and added hospice care. The Program failed to update the service plan, dated 5/3/22, following the evaluation of these additions to her care. On 10/11/22 at 3:00 p.m. the Director confirmed these findings.	A 350		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop an individualized service plan to meet the identified needs of the tenants. This pertained to 1 of 1 tenants with history of elopement and aggressive behavior (Tenant #1). Findings follow: Record review on 10/6/22 of Tenant #1's file revealed the following: 1. Progress Notes documented two elopements and six incidents of physical aggression, verbal, and/or sexual behaviors toward staff and/or	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0259	A. BUILDING: _____ B. WING _____	C 10/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF OTTUMWA	173 EAST ROCHESTER STREET OTTUMWA, IA 52501

(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 395	Continued From page 8	A 395		

tenants from 4/10/22 to 5/23/22. On 4/2/22 he was sent to the hospital for treatment of his behavior. Continued review of notes from 7/25/22 to 8/24/22 revealed two incidents of urinating in the hallway, two elopement attempts, and five incidents of physical/sexual aggression. On 8/24/22 he was sent to the emergency room for physical aggression towards staff.

Tenant #1's Service Plan, dated 5/18/22, revealed he was a high risk for elopement due to attempts at previous facility and required safety checks 32 times per shift. The service plan failed to include specific interventions to minimize the risk of elopement and aggressive behaviors.

On 10/3/22 at 12:51 p.m. Staff E stated Tenant #1 displayed physical, verbal, and/or sexual behavior and was hard to manage with only one staff in the memory care unit. She confirmed he required 15 minute checks and stated staff could not do this and take care of the other tenants.

On 10/6/22 at 1:17 p.m. Staff F confirmed Tenant #1 required 15 minutes checks due to behavior. She stated he attempted to leave the memory care unit several times and succeeded in the leaving the unit a few times but remained in the building. She said it was very difficult to provide care to the other tenants in the memory care with only one staff. She reported she discussed this with the previous nurse several times and she would only call his physician for med changes.

On 10/11/22 at 3:00 p.m. the Director confirmed these findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER:	DATE SURVEY COMPLETED: 10/10/2022

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag # 1	**Regulation and Reg Number** 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: A 150 Based on observation, interview, and record review the Program failed to follow its policy for COVID-19 precautions. This potentially affected all 24 tenants.	A150	Staff education provided on Covid Policy and Procedures with focus on mask use on 10/10/ 22. Masks are available at screening stations.	Re-education and training of staff regarding covid policies in accordance with CDC recommendations. Audit of mask compliance will be performed weekly, monthly, as determined by the director or designee.	Implementation Date: 10/11/2022 Completion Date: Ongoing Responsible Party: Director or Designee
Tag # 2	**Regulation and Reg Number** 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:	A 285	Previous HCC no longer employed. Separation date 9/15/2022. New HCC educated upon hire on medication processes and expectations. Existing orders for tenant C3 clarified on 10/10/22.	New HCC educated upon hire on medication processes and expectations.	Implementation Date:10/10/22 Completion Date: Ongoing

	(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 provide medical treatments as ordered by a physician. This pertained to 1 of 1 tenants that required International Normalized Ration (INR) checks for blood thinners (Tenant C3).				Responsible Party: Director or designee.
Tag #3	**Regulation and Reg Number** 481-67.9(1) Staffing 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: A 325 Based on interview and record review the Program failed to have a sufficient number of staff available to meet the identified needs of the tenants in the memory care unit. This pertained	A 325	Staff reeducated on timeliness of documentation of POC tasks on 12/10/22.	All new hires will be trained in the use of IPad and POC documentation requirements. Director and or designee will routinely audit POC task documentation and provide education as concerns are noted.	Implementation Date: 12/10/22 Completion Date: Ongoing Responsible Party: Director or designee.

	to 1 of 1 current tenants (Tenant #1) and 1 of 1 discharged tenants (Tenant C2) requiring safety checks every 15 minutes and potentially affected all tenants in the memory care unit.				
Tag #4	**Regulation and Reg Number** 481-69.23(1)c(1) Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to discharged tenants who chronically displayed unmanageable elopement and verbal and physically abusive behaviors. This pertained to 1 of 1 tenants with history of elopement and aggressive behavior (Tenant #1).	A 160	Tenant #1 discharged on 10-8-22. Tenant #2 discharged on 9-17-22.	New HCC was trained on admission and retention criteria of tenants. All staff reeducated on when and how to use staff to nurse communication form. Director or designee will routinely audit to ensure regulatory compliance.	Implementation Date:1-3-2023 Completion Date: Ongoing Responsible Party: Director or designee

Tag #5	**Regulation and Reg Number** 481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: A 350 Based on interview and record review the Program failed to update service plans based on the required evaluations to meet the specific needs for 1 of 2 discharged tenants reviewed with hospice care (Tenant C1).	A 350	Tenant #3 discharged on 7-19-21. Tenant#1 discharged on 10-8-22.	New HCC was trained on proper completion of COC and ISP. Director or designee will routinely audit to ensure regulatory compliance. All staff reeducated on when and how to use staff to nurse communication form.	Implementation Date:01/03/2023 Completion Date: Ongoing Responsible Party: Director or Designee.
Tag# 6	**Regulation and Reg Number** 481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: A 395 Based on interview and record review the Program failed to develop an individualized service	A 395	Tenant#1 discharged on 10-8-22.	New HCC was trained on proper completion of COC and ISP. Director or designee will routinely audit to ensure regulatory compliance. All staff reeducated on when and how to use staff to nurse communication form.	Implementation Date:1-3-2023 Completion Date: Ongoing Responsible Party:

	plan to meet the identified needs of the tenants. This pertained to 1 of 1 tenants with history of elopement and aggressive behavior (Tenant #1).				Director or designee

Compliance Date: 03/12/23

2/10/25 Executive Director

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.