STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0285	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF CARROLL	1214 EAST 18TH STREET CARROLL, IA 51401

(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: 29 Number of tenants with cognitive impairment: 17 Total census: 46 No regulatory insufficiencies were cited during the investigation of Incident #129989-I. The following regulatory insufficiencies were cited during the investigation of Complaints #127949-C and 129567-C.	A 000	See attached POC 7/23/25	
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the delegating nurse failed to consistently ensure staff were sufficiently trained within 30 days of employment. This pertained to 1 of 3 staff (Staff A). Finding follows: Record review on 7/21/25 revealed the Program hired Staff E 10/21/24. The Program nurse	A 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0285	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF CARROLL	1214 EAST 18TH STREET CARROLL, IA 51401

(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 345	Continued From page 1 completed delegations with Staff A on 12/11/24. During the exit interview on 7/24/25 at 2:00 p.m. the administrative team acknowledged the Program failed to complete delegations within 30 days of employment as required.	A 345		
A 115	481-69.21(2)a,b,c,d,e,f Occupancy Agreement 69.21(2) In addition to the requirements of Iowa Code section 231C.5, the written occupancy agreement shall include, but not be limited to, the following information in the body of the agreement or in the supporting documents and attachments: a. The telephone number for filing a complaint with the department. b. The telephone number for the office of long-term care ombudsman. c. The telephone number for reporting dependent adult abuse. d. A copy of the program ' s statement on tenants' rights. e. A statement that the tenant landlord law applies to assisted living programs. f. A statement that the program will notify the tenant at least 90 days in advance of any planned program cessation, which includes voluntary decertification, except in cases of emergency. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure occupancy agreements included required information. This pertained to 5	A 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0285	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF CARROLL	1214 EAST 18TH STREET CARROLL, IA 51401

(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 115	Continued From page 2 of 5 sample tenants (Tenants #1 -#5). Findings follow: Record review on 7/21/25 revealed the Program's Occupancy Agreements (OA) for Tenants #1 -#4 failed to clearly state Dependent Adult Abuse should be reported to the Department of Inspections Appeals and Licensing (the Department). The OA included the Department's telephone number to report/file complaints but did not clearly explain Dependent Adult Abuse allegations should be reported to the same telephone number. Further review of Tenant #1's OA revealed the Program failed to include the telephone number for filling a complaint with the Department and the office of long-term care ombudsman's office. In addition, the Program failed to include a statement that the program will notify the tenant at least 90 days in advance of any planned program cessation, which includes voluntary decertification, except in cases of emergency. During the exit on 7/24/25 at 2:00 p.m. the administrative team acknowledged the Program failed to follow the rules regarding Occupancy Agreements.	A 115		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0285	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF CARROLL	1214 EAST 18TH STREET CARROLL, IA 51401

(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 145	Continued From page 3 be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete thorough evaluations to include tenants' functional, cognitive and health status as required. This pertained to 5 of 5 tenants reviewed (Tenants #1 - #5). Finding follows: Record review on 7/21/25 revealed the following regarding evaluations: Tenant #1's dated 3/25/25. Tenant #2's dated 6/17/25. Tenant #3's dated 6/24/25 Tenant #4's dated 5/16/25 Tenant #5's dated 4/16/25 The evaluations included cognitive and functional evaluations, but failed to include evaluation of tenants' health status. During the exit on 7/24/25 at 2:00 p.m. the administrative staff confirmed the Program failed to complete health evaluations as required.	A 145		
A 395	481-69.26(4)a Service Plans	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0285	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF CARROLL	1214 EAST 18TH STREET CARROLL, IA 51401

(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 4 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 individualized service plans to include tenants' identified needs and preferences for assistance. This pertained to 5 of 5 sample tenants (Tenants #1-#5). Finding follows: Record review on 7/22/25 revealed the following tenant service plans failed to identify tenants needs and preferences for assistance: Tenant #1's dated 3/25/25. Tenant #2's dated 6/17/25. Tenant #3's dated 6/24/25 Tenant #4's dated 5/16/25 Tenant #5's dated 4/16/25 During the exit on 7/23/25 at 2:00 p.m. the administrative team explained the Program would be implementing a new system to develop services plans that were more inclusive.	A 395		
A 410	481-69.26(4)d Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of	A 410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0285	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF CARROLL	1214 EAST 18TH STREET CARROLL, IA 51401

(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 410	Continued From page 5 person-centered planned and spontaneous activities based on the tenant's abilities and personal interests. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to include planned and spontaneous activities on the service plans for 2 of 2 current tenants residing in the memory care unit (Tenants #2 and #4). Findings follow: Record review on of tenant files revealed the following: Tenant #2's Global Deterioration Scale dated 7/17/24 revealed a score of 6 and indicated severe cognitive decline. The service plan failed to include activities based on her preferred interests and abilities. Tenant #4's Global Deterioration Scale dated 8/29/24 revealed a score of 5 and indicated moderately severe cognitive decline. The service plan failed to include activities based on her preferred interests and abilities. During the exit on 7/23/25 at 2:00 p.m. the administrative team explained the Program would be implementing a new system to develop services plans that were more inclusive.	A 410		
A 415	481-69.26(4)e Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: e. Preferences, if any, of the tenant or the	A 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0285	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF CARROLL	1214 EAST 18TH STREET CARROLL, IA 51401

(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 415	Continued From page 6 tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to include tenant preference for nursing facility care. This pertained to 5 of 5 tenants reviewed (Tenants #1 - #5). Findings follow: Record review on 7/22/25 revealed tenant service plans failed to include nursing facility preference for the following tenants: Tenant #1's dated 3/25/25 Tenant #2's dated 6/17/25 Tenant #3's dated 6/24/25 Tenant #4's dated 5/16/25 Tenant #5's dated 4/16/25 During the exit on 7/23/25 at 2:00 p.m. the administrative team explained the Program would be implementing a new system to develop services plans that were more inclusive.	A 415		
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 employment or the beginning date of the contract, as applicable.	A 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0285	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF CARROLL	1214 EAST 18TH STREET CARROLL, IA 51401

(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 545	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure staff received eight hours of dementia-specific education within 30 days of employment. This pertained to 2 of 2 current staff reviewed (Staff A and B). Findings follow: Record review on 7/21/25 revealed the Program hired Staff A on 10/21/24. Further record review revealed Staff A failed to complete eight hours of training within 30 days of employment. Record review on 7/21/25 revealed the Program hired Staff B on 2/10/25. Further record review revealed Staff B failed to complete eight hours of training within 30 days of employment. During the exit on 7/21/25 at 2:00 p.m. the administrative team acknowledged staff had not completed dementia training within 30 day of employment as required.	A 545		

ok
9/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0285	DATE SURVEY COMPLETED: 07/23/2025

This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute admission on the part of the Community as to the accuracy of the survey's findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, manager, director, attorney or shareholder of the Community or affiliated companies.

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	**481-67.9(4)b Staffing** 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the delegating nurse failed to consistently ensure staff were	**A 345**	**What initial correction was made?** Nurse delegations for cares were reviewed/evaluated with all care staff and appropriately signed off on each delegation task. Nurse will train and evaluate new employees with all cares and sign off on each delegation task prior to the end of their orientation.	**How will we ensure and maintain compliance going forward?** DHW or designee will review/evaluate all care staff annually on each delegation task and the Nurse will complete the Nurse Delegation Form and place in employees file. DHW will train and evaluate all new employees on each delegation task prior to the end of their orientation and before working on the floor independently.	**Implementation Date:** 07/23/2025 **Completion Date:** On-going **Responsible Party: DHW and/or designee**

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. **Compliance Date: 8/19/2025**

	sufficiently trained within 30 days of employment. This pertained to 1 of 3 staff (Staff A). Finding follows: Record review on 7/21/25 revealed the Program hired Staff E 10/21/24. The Program nurse completed delegations with Staff A on 12/11/24. During the exit interview on 7/24/25 at 2:00 p.m. the administrative team acknowledged the Program failed to complete delegations within 30 days of employment as required.				
Tag #2	**481-69.21(2) a, b, c, d, e, f Occupancy Agreement** 69.21(2) In addition to the requirements of Iowa Code section 231 C.5, the written occupancy agreement shall include, but not limited to, the following information in the body of the agreement or in the supporting documents and attachments: a. The telephone number for filing a complaint with the department. b. The telephone number for the office of the long-term care ombudsman.	**A 115**	**What initial correction was made?** Developed a revised occupancy agreement addendum for all current residents or responsible parties to acknowledge and sign. Going forward, document regarding Dependent Adult Abuse will be printed and given to families.	**How will we ensure and maintain compliance going forward?** This addendum and print out will be added to the occupancy agreement and included with all future signings.	**Implementation Date:** 07/23/2025 **Completion Date:** On-going **Responsible Party: Director and/or designee**

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. **Compliance Date: 8/19/2025**

	c. The telephone number for reporting dependent adult abuse. d. A copy of the program's statement on tenant's rights. e. A statement that the tenant landlord law applies to assisted living programs. f. A statement that the program will notify the tenant at least 90 days in advance of any planned program cessation, which includes voluntary decertification, except in cases of emergency. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure occupancy agreements included required information. This pertained to 5 of 5 sample tenants (Tenants #1-#5). Findings follow: Record review on 7/21/25 revealed the Program's Occupancy Agreements (OA) for Tenants #1-#4 failed to clearly state Dependent Adult Abuse should be reported to the Department of Inspections Appeals and Licensing (the Department). The OA included the Department's telephone number to				

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	report/file complaints but did not clearly explain Dependent Adult Abuse allegations should be reported to the same telephone number. Further review of Tenant #1's OA revealed the Program failed to include the telephone number for filing a complaint with the Department and the office of long-term care ombudsman's office. In addition, the Program failed to include a statement that the program will notify the tenant at least 90 days in advance of any planned program cessation, which includes voluntary decertification, except in cases of emergency. During the exit on 7/24/25 at 2:00 p.m. the administrative team acknowledged the Program failed to follow the rules regarding the Occupancy Agreements.				
Tag #3	**481-69.22(3) Evaluation of Tenant** 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less	**A 145**	**What initial correction was made?** DHW will be educated on Policy AS01-Asessments conducted by the Regional Director of Resident Care. The resident Assessment are completed/updated: a. Prior to move-in.	**How will we ensure and maintain compliance going forward?** DHW and/or Designee will audit four resident's charts once per week for eight weeks for changes to ensure all residents residing in the community have functional, cognitive and health status	**Implementation Date:** 07/23/2025 **Completion Date:** On-going

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. **Compliance Date: 8/19/2025**

	than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete thorough evaluations to include tenant's functional, cognitive and health status as required. This pertained to 5 of 5 tenants reviewed (Tenants #1-#5). Finding follows: Record review on 7/21/25 revealed the following regarding evaluations: Tenant #1's dated 3/25/25. Tenant #2's dated 6/17/25. Tenant #3's dated 6/24/25.		b. 30 days after move-in. c. Every six (6) months. d. Whenever there is a significant change in resident status.	evaluations and service plans documented accurately. Once the initial audit is completed, resident charts will be audited on a quarterly basis.	**Responsible Party: DHW and/or designee**

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. **Compliance Date: 8/19/2025**

	Tenant #4's dated 5/16.25. Tenant $5's dated 4/16/25. The evaluations included cognitive and functional evaluations, but failed to include evaluation of tenant's health status. During the exit on 7/24/25 at 2:00 p.m. the administrative staff confirmed the Program failed to complete health evaluations as required.				
Tag #4	**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 individualized service plans to include tenant's identified needs and preferences for assistance. This pertained to 5 of 5 sample tenants (Tenants #1-#5). Finding follows:	**A 395**	**What initial correction was made?** DHW and/or Designee will correct resident individualized service plans to reflect their needs and preferences for assistance as needed.	**How will we ensure and maintain compliance going forward?** DHW and/or designee will ensure needs and preferences for assistance for residents moving in to the community is stated in their individualized service plans.	**Implementation Date:** 07/23/2025 **Completion Date:** On-going **Responsible Party: DHW and/or designee**

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. **Compliance Date: 8/19/2025**

	Record review on 7/22/25 revealed the following tenant service plans failed to identify tenants needs and preferences for assistance: Tenant #1's dated 3/25/25. Tenant #2's dated 6/17/25. Tenant #3's dated 6/24/25. Tenant #4's dated 5/16/25. Tenant #5's dated 4/16/25. During the exit on 7/23/25 at 2:00 p.m. the administrative team explained the Program would be implementing a new system to develop service plans that were more inclusive.				
Tag #5	**481-69.26(4)d Service Plans** 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to include planned	**A 410**	**What initial correction was made?** Ensure Life Stories are uploaded into the new documentation system (Extended Care Professional) and attached to the service plan.	**How will we ensure and maintain compliance going forward?** Ensure Life Stories are attached to service plans going forward for all new residents. Audit to be completed quarterly for 6 months.	**Implementation Date:** 07/23/2025 **Completion Date:** 01/23/2026 **Responsible Party: Director and/or designee**

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. **Compliance Date: 8/19/2025**

	and spontaneous activities on the service plans for 2 of 2 current tenants residing in the memory care unit (Tenants #2 and #4). Findings follow: Record review on of tenant files revealed the following: Tenant #2's Global Deterioration Scale dated 7/17/24 revealed a score of 6 and indicated severe cognitive decline. The service plan failed to include activities based on her preferred interests and abilities. Tenant #4's Global Deterioration Scale dated 8/29/24 revealed a score of 5 and indicated moderately severe cognitive decline. The service plan failed to include activities based on her preferred interests and abilities. During the exit on 7/23/25 at 2:00 p.m. the administrative team explained the Program would be implementing a new system to develop service plans that were more inclusive.				

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. **Compliance Date: 8/19/2025**

Tag #6	**481-69.26(4)e Service Plans** 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: e. Preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to include tenant preference for nursing facility care. This pertained to 5 of 5 tenants reviewed (Tenants #1-#5). Findings follow: Record review on 7/22/25 revealed tenant service plans failed to include nursing facility preference for the following tenants: Tenant #1's dated 3/25.25. Tenant #2's dated 6/17/25. Tenant #3's dated 6/24/25. Tenant #4's dated 5/16/25. Tenant #5's dated 4/16/25. During the exit on 7/23/25 at 2:00 p.m. the administrative team explained the	**A 415**	**What initial correction was made?** All residents will have a Long Term Care facility added to their resident file attached to the service plan.	**How will we ensure and maintain compliance going forward?** DHW and/or Designee will ensure at move in that a preferred Long Term Care facility is designated and added to their file attached to the service plan.	**Implementation Date:** 7/23/2025 **Completion Date:** 9/30/2025 and on-going **Responsible Party: DHW and/or designee**

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. **Compliance Date: 8/19/2025**

	Program would be implementing a new system to develop service plans that were more inclusive.				
Tag #7	**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 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 consistently ensure staff received eight hours of dementia-specific education within 30 days of employment. This pertained to 2 of 2 current staff reviewed (Staff A and B). Findings follow: Record review on 7/21/25 revealed the Program hired Staff A on 10/21/24. Further record review revealed Staff A failed to complete eight hours of training within 30 days of employment.	**A 545**	**What initial correction was made?** All employees will complete Relias training courses, including all Dementia training, prior to starting to shadow direct care.	**How will we ensure and maintain compliance going forward?** Director and/or Designee will ensure all online training, including dementia training, is complete prior to shadowing direct care.	**Implementation Date:** 07/23/2025 **Completion Date:** On-going **Responsible Party: Director and/or Designee**

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. **Compliance Date: 8/19/2025**

	During the exit on 7/21/25 at 2:00 p.m. the administrative team acknowledged staff had not completed dementia training within 30 days of employment as required.				

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