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
	S0285	A. BUILDING: _____ B. WING _____	C 01/07/2026

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

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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: 26 Tenants with cognitive impairment: 16 Total census: 42 The following regulatory insufficiencies were cited during the investigation of Complaint #130751-C, #130778-I, and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000	See attached POC 4/15/26	
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 established policies affecting 2 of 5 tenants reviewed (Tenant #1 and Tenant #5). Findings follow: Record review on 1/06/26 and 1/07/26 revealed the following: 1. An incident report dated 11/01/25 revealed Tenant #1 had an unwitnessed fall which, Tenant #1 reported to staff reportedly occurred on the evening of 10/31/25 around 11:30 p.m.. Per the incident report Resident Statement, Tenant #1 stated she went to go to the bathroom, then to	A 150	A 150 - 481-67.2(3) Program Policies and Procedures DHW will verify physician orders and ensure accurate entry into MAR. Staff will be re-educated on completing required visual safety checks per individualized service plans. The DHW/ED/or designee will audit new medication orders and visual safety check documentation weekly for 90 days to ensure compliance with program policies.	4/15/26

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A 150	Continued From page 1	A 150		

get a drink of water and tripped over her blanket. Tenant #1 indicated she laid on the floor the rest of the night, no one checked on her, and she tried to call the Program three times and no one answered the phone so she called 911 on the morning of 11/01/25 around 9:45 a.m. The Program's internal investigation of the incident revealed the Program staff was unaware of Tenant #1's fall and the need for assistance until emergency personnel arrived in response to the 911 call. Tenant #1 was transported to the hospital for further evaluation and monitored for an elevated Troponin level. There were no other injuries noted from the fall. They were not able to determine if the elevated Troponin level was a result of the fall or a precursor which contributed to the fall. She returned back to the Program.

Tenant #1 admitted to the Program 9/09/23 and diagnoses included Atherosclerotic heart disease, atrial flutter, non-ST elevation myocardial infarction, osteoarthritis, disorders of bone density and structure, chronic kidney disease, malignant neoplasm of the colon, hyperlipidemia, essential (primary) hypertension, and unspecified dementia without severity. Tenant #1 scored a three on the Global Deterioration Scale (GDS) which indicated only a mild cognitive impairment.

During the course of the Program's internal investigation, it was determined Tenant #1 was not wearing her call pendant at the time of the fall. The Program reviewed the work phones and no calls were received in to the Program and determined Tenant #1 likely misdialed during her attempts to reach Program staff. The Program further determined an overnight staff member (Staff A) failed to conduct the overnight visual

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A 150	Continued From page 2	A 150		

safety check for Tenant #1 per her service plan, despite having documented a visual safety check at 6:13 a.m. at the end of Staff A's shift on the morning of 11/01/25. At the conclusion of the Program's internal investigation, Staff A was terminated from employment.

During an interview on 1/06/26, Tenant #1 shared she fell on the evening of 10/31/25 but didn't have her call pendant to call for assistance, didn't holler out for help, and didn't recall having her phone during the incident. She indicated she couldn't get up, and no staff came to check on her and she laid on the floor for several hours until the next morning. Review of the layout of Tenant #1's room and description of the incident of the location of the fall within her apartment from Tenant #1 revealed Tenant #1 would have been in direct line of sight from the apartment door.

Review of Tenant #1's service plan dated 10/01/25, reflected Tenant #1 was independent with most Activity of Daily Living (ADL) tasks but required a visual safety check to "lay eyes on resident to ensure safety" one time per shift. The service plan noted she was capable of pressing her pendant. She occasionally was confused and had some difficulty recalling details and needed some prompting following directions or notes.

Review of the ADL task documentation for the timeframe of the incident noted the 6:13 a.m. documented entry time by Staff A of a visual check. It further noted no visual safety check had been completed by Program staff during the evening shift of 10/31/25 per Tenant #1's statement of the approximate time of the fall.

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A 150	Continued From page 3 Further review of the October and November 2025 visual check documentation noted missing visual checks on: 2nd shift check on 10/18/25, 3rd shift check on 10/26/25, 2nd and 3rd check on 11/06/25, 3rd shift check on 11/08/25, 3rd shift on 11/12/25, 3rd shift on 11/18/25, 3rd shift check on 11/22/25, and 2nd shift on 11/27/25. A review of the Program's policy entitled "Monitoring Residents" indicated tenants will be checked on in accordance with their individualized service plan. When interviewed on 1/06/26 at 4:45 p.m., the Executive Director (ED) reviewed the ADL visual task documentation from the dates of 10/31/25 and 11/01/25 and confirmed the documentation. 2. Tenant #5 was observed during a 2:00 p.m. medication pass on 1/06/26 and further reviewed. At the time of the medication pass by Staff B, it was noted Tenant #5's Furosemide medication bubble pack was labeled with a sticker which indicated the medication was to be administered at noon. Review of the physician's orders for Tenant #5 confirmed the orders were for 40 Milligram(s) (mg),one tablet of Furosemide to be administered at noon. Following the administration/medication pass Staff B further investigated and determined the medication labeling was correct, but had been entered into the electronic medication administration record (MAR) system incorrectly. A review of the Medication Administration Record (MAR) for January 2026 revealed due to the entry error, Tenant #5's Furosemide medication had been administered at 2:00 p.m. outside of the one-hour window of noon administration time on the dates	A 150		

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A 150	Continued From page 4 of 1/01/26 through 1/06/26. A review of the Program's policy, "Receiving Medications" dated 6/13/24 included: -All medications, including over-the-counter (OTC) medications, must be verified for accuracy and labeling prior to being placed in central storage. -Verify the physician's order has been transcribed on the MAR correctly. When interviewed on 1/06/26 at 4:45 p.m., the Executive Director (ED) confirmed the medication dosage time was incorrect in the electronic medication administration record system and stated the Program corrected the order in the system on this day. On 1/07/26 at 11:00 a.m. the Executive Director and Regional nurse/current interim delegating Program nurse confirmed the above findings related to Tenant #1 and Tenant #5.	A 150		
A 370	481-69.26(3)a 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. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	A 370	A 370 - 481-69.26(3)a Service Plans The DHW has been oriented to requirements to ensure service plans are signed and dated following a significant change. The ED/DHW/Designee will audit new significant change service plans weekly for 90 days to ensure required signatures and dates are present.	4/15/2026

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A 370	Continued From page 5 Program failed to ensure the service plans related to significant change were signed and dated by all parties for 2 of 5 tenants reviewed (Tenant #3 and Tenant #4). Findings follow: Record review on 1/06/26 revealed: 1. The Program provided a change of condition assessment for Tenant #3, completed and signed 8/27/25 by the delegating nurse, and then signed by the tenant's representative and Executive Director on 10/07/25. The provided service plan for Tenant #3 showed a print date of 1/06/26 but was not signed or dated by any parties. 2. The Program provided a change of condition assessment for Tenant #4, completed and signed 8/26/25 by the delegating nurse, and then signed by the tenant's representative and Executive Director on 9/04/25. The provided service plan for Tenant #4 showed a print date of 1/06/26 but was not signed or dated by any parties. When interviewed on 1/06/26 at 4:45 p.m., the Executive Director (ED) confirmed service plans were to be signed/dated by all parties following a significant change but believed the Program did not have record of a signed/dated service plan following the significant change for either Tenant #3 or Tenant #4. On 1/07/26 at 11:00 a.m. the Executive Director and Regional nurse/current interim delegating program nurse confirmed the above findings.	A 370		
			A 395- 481-69.26(4)a Service Plans The DHW has been oriented to requirements to ensure service plans are individualized and updated with changes in services.	4/15/2026
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 395	The ED/DHW/Designee will audit new service plans weekly for 90 days to ensure service plans accurately reflect tenant needs.	

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A 395	Continued From page 6 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 ensure service plans were individualized and accurately addressed needs for 1 of 5 tenants reviewed (Tenant #2). Finding follows: Record review on 1/06/26 revealed Tenant #2 admitted to the Program on 11/17/24. An entrance form provided by the Program identified Tenant #2 received hospice services. Review of the service plan, dated 5/08/25, under the section Third Party Provider Services reflected Tenant #2 utilized Home Health services. Under the line item "Resident utilizes Hospice" the service plan reflected "No". Continued review revealed a hospice admit order for Tenant #2 was dated 11/04/25. The service plan for Tenant #2 was not updated following the discontinuation of home health services and significant change to hospice services. When interviewed on 1/06/26 at 4:45 p.m., the Executive Director (ED) confirmed Tenant #2 no longer required home health services, but was instead now on hospice services and the service plan for Tenant #2 had not been updated to reflect the change. On 1/07/26 at 11:00 a.m. the Executive Director and Regional nurse/current interim delegating program nurse confirmed the above findings.	A 395		

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