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
	S0287	A. BUILDING: _____ B. WING _____	C 05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF BURLINGTON	5175 WEST AVENUE BURLINGTON, IA 52601

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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: 43 Tenants with cognitive impairment: 13 Total census: 56 No regulatory insufficiencies were cited during the investigation of Incident #131514-I and Complaint #132044-C. The following regulatory insufficiencies were cited during the investigation of Complaint #132142-C.	A 000		
A 200	481-67.9(4)f Staffing 481-67.9(231B,231C,231D) 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 include the following: f. Services will be provided to tenants in accordance with the training provided. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure staff provided care, services, safety checks, medication administration, and blood pressure monitoring in accordance with established training guidelines and individual service plan directives. This pertained to 1 of 4 tenants whose files were	A 200		

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A 200	Continued From page 1 reviewed (Tenant #1). Findings follow: 1. A Program training document titled "Nurse Delegation for Visual Checks," dated March 2021, outlined mandatory protocols for completing tenant safety checks. Training instructions required staff to use an iPad, go to the tenant ' s apartment, knock on the door, and make direct visual contact with the tenant, whether awake or sleeping. Staff were required to document the visual check in the electronic system according to the scheduled time. If a tenant was not located in the apartment, instructions mandated staff check throughout the community and notify other staff until the person was found. The training tool noted falsification of documentation could lead to counseling or termination. A separate undated training document titled "Nurse Delegation for Medication Management" outlined mandatory medication administration protocols. Directives required staff to initial the dose on the electronic medication administration record, administer the correct medication to the correct tenant at the correct time using the correct route, and ensure the medication was swallowed. If a tenant refused medication, staff instructions required documentation of the refusal and immediate notification to the nurse. Record review on 5/20/26 revealed a Med Pass History Report indicating Staff A signed off as having successfully provided Tenant #1 her scheduled evening medication on 5/10/26 at 8:03 p.m. Review of the Task Administration Record and Care History Report revealed consecutive	A 200		

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electronic documentation entries verifying Tenant #1 was present in the building:

Staff B documented the completion of a safety check on 5/10/26 during the 2:00 p.m. to 10:00 p.m. shift.

Staff C documented seeing the tenant (erroneously recorded as Tenant C1) on 5/11/26 at 1:06 a.m.

Staff D documented performing a safety check on 5/11/26 at 6:29 a.m.

During an interview on 5/19/26 at 7:12 p.m., Staff B stated he completed evening rounds around 10:00 p.m. on 5/10/26 and heard sounds coming from Tenant #1's apartment. Staff B stated he believed at the time the noise was Tenant #1, though he now believed the sounds came from a radio. Staff B confirmed he did not see Tenant #1 at 10:00 p.m. when conducting evening safety checks, noting the last time he saw her was between 7:00 p.m. and 7:30 p.m. on 5/10/26.

During an interview on 5/20/26 at 7:12 a.m., Staff C reported he and Staff B completed safety checks together on 5/10/26. Staff C stated Staff B told him Tenant #1 was in her apartment at 10:00 p.m., and Staff C entered this information into the electronic record at 1:06 a.m. on 5/11/26. Staff C confirmed he did not see Tenant #1 during his shift.

During an interview on 5/20/26 at 10:50 a.m., Staff D stated she did not complete a safety check on Tenant #1 at 6:29 a.m. on 5/11/26 despite logging the entry. Staff D stated she was passing medications to other tenants at the time and assumed co-workers handled the safety

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checks. Staff D stated because no one told her Tenant #1 was missing from the building, she documented the tenant was present. Staff D further stated she entered Tenant #1's apartment to provide medication around 8:32 a.m. on 5/11/26 based on information from a Med Pass History Report. Staff D stated she thought she heard Tenant #1 in the bathroom, prepared the medication, and left the pills on the counter. Staff D stated when she realized Tenant #1 was not in the apartment, she retrieved the medication, saved the pills for later, and subsequently destroyed them due to becoming busy with call lights.

During an interview on 5/21/26 at 11:45 a.m., Staff E reported she observed Tenant #1's apartment door open during morning safety checks on 5/11/26 but failed to put eyes on her or make direct visual contact. Staff E stated she realized Tenant #1 was missing from breakfast, and asked Staff D if she had seen the tenant. Staff E stated Staff D reported she had not seen Tenant #1 and had left her medication on the counter inside the apartment. Staff E stated Tenant #1 had told her on 5/10/26 she wanted to move to a homeless shelter because the Program was stealing her money and making her sick. Staff E stated once she learned no one could locate Tenant #1 on 5/11/26, she reported this details to the Executive Director, who instructed her to notify the nurse. Review of a Staff Documentation/Communication to Nurse form verified Staff E completed written notification regarding the tenant's statements morning of 5/11/26.

During an interview on 5/19/26 at 5:10 p.m., the Director of Health and Wellness stated she received a telephone call from a medical

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secretary at Tenant #1's Primary Care Provider's (PCP's) office on 5/11/26 at 1:35 p.m. The secretary reported Tenant #1 spent the previous night in a motel without the knowledge of anyone at the Program, was currently at the medical clinic, and requested her medication. The Director of Health and Wellness confirmed this telephone call was the first time she became aware Tenant #1 was missing from the building. She stated she initially told the clinic staff Tenant #1 was safe inside the building and had received her morning medication because the administration was marked as completed on the MAR. The Director of Health and Wellness stated she initiated an investigation after speaking with Staff D and learning the employee never saw Tenant #1 morning of 5/11/26. The Director of Health and Wellness noted Tenant #1 had a mild cognitive impairment, making it safe to leave the building with a friend, but noted the tenant was expected to notify staff or sign out.

During an interview on 5/20/26 at 12:35 p.m., the Director of Health and Wellness stated staff are trained to check on tenants once per shift, set eyes on residents to ensure safety, and immediately document the visual check using their assigned iPads. She verified the staff person completing the check is solely responsible for entering the documentation. The Director of Health and Wellness stated if Tenant #1 left the building prior to 10:00 p.m. on 5/10/26, Staff B should have discovered she was gone. She confirmed Staff B was responsible for logging the entry, and Staff C should not have documented the check at 1:06 a.m. She further confirmed Staff D should not have documented the safety check on 5/11/26 at 6:29 a.m. During a subsequent interview on 5/21/26 at 2:10 p.m., the Director of Health and Wellness confirmed Staff

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A 200	Continued From page 5 D should not have marked the medication as administered on the MAR and should never have left the prescription pills unattended on the counter. 2. Review of Tenant #1's Resident Information Sheet revealed diagnoses including Non-ST elevation (NSTEMI) myocardial infarction, essential hypertension, nonrheumatic mitral valve insufficiency, unspecified atrial fibrillation, heart failure, and a ruptured aneurysm of the ascending aorta. Review of Tenant #1's individual service plan dated 5/19/26 revealed a mandatory directive requiring staff to obtain the tenant's blood pressure daily and immediately report abnormal readings to the nurse. A Program training document titled "Nurse Delegation Form: Measuring Blood Pressure," dated 6/30/25, instructed staff to immediately report any blood pressure readings measuring 160/100 mmHg and above, or 90/60 mmHg and below, to the nurse. Review of Tenant #1 ' s Vitals History Report spanning from 3/1/26 to 5/20/26 revealed critical, life-threatening blood pressure readings on the following dates: 4/22/26: 184/119 mmHg 4/26/26: 197/125 mmHg 5/19/26: 169/154 mmHg The medical record lacked any documentation verifying staff reported these critical values to the nurse or clinical leadership.	A 200		

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A 200	Continued From page 6 During an interview on 5/26/26 at 11:47 a.m., the Director of Health and Wellness stated staff initiated daily blood pressure checks for Tenant #1 on 4/3/26 because the tenant became hyperfixated on having the measurements taken. During a subsequent interview on 5/21/26 at 8:28 a.m., the Director of Health and Wellness confirmed staff were required to notify her of the critical blood pressure readings obtained on 4/22/26, 4/26/26, and 5/19/26, but failed to do so.	A 200		
A 232	481-69.22(3) Evaluation of Tenant 481-69.22(231C) 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 be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure evaluations were completed to address a significant change in condition. This pertained to 1 of 4 current tenants whose service plans were reviewed (Tenant #1). Findings follow: Record review on 5/21/26 of a Vital History report spanning from 3/1/26 through 5/20/26 revealed	A 232		

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staff checked Tenant #1's blood pressure once in March (3/8/26). The record verified that beginning on 4/3/26, her blood pressure measurements transitioned to a daily frequency.

Continued record review revealed a Staff Documentation/Communication to Nurse form dated 5/11/26 verified an employee completed written notification to the Director of Health and Wellness and the Executive Director morning of 5/11/26, reporting Tenant #1 had expressed a desire to leave the facility and move to a homeless shelter.

When interviewed on 5/19/26 at 4:40 p.m., Staff A stated Tenant #1 had not been acting like herself for the past month. Staff A stated she seemed worried about the air quality, purchased two separate air purifiers, and began asking to sleep in different apartments to determine if other rooms had less of an effect on her allergies. Staff A noted her conversations no longer made sense, she was frequently found wandering around the building, and she slept in a facility model apartment the night of 5/9/26 because she claimed something in her own apartment made her uncomfortable.

During an interview on 5/20/26 at 7:12 a.m., Staff C reported noticing a progressive change in Tenant #1 over the preceding two weeks. Staff C stated she repeatedly asked to sleep in different apartments and kept asking him to check her blood pressure during the night up to three times per shift. Staff C verified these behaviors were entirely new actions for the tenant.

When interviewed on 5/20/26 at 7:45 a.m., Staff F stated he observed a distinct change in Tenant #1's behavior over the past week. Staff F stated

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A 232	Continued From page 8 she wanted to spend nights in three different apartments, spent the night in another resident's apartment on one occasion, and repeatedly claimed her allergies were worse inside her assigned room. During an interview on 5/20/26 at 10:10 a.m., Staff G stated Tenant #1 appeared increasingly confused lately compared to when she initially moved to the Program two months prior. Staff G stated she refused to sleep in her bed due to a belief something was wrong with it, vocalized she was unable to remain in the building, and appeared to be distancing herself from everyone. When interviewed on 5/20/26 at 11:30 a.m., the Director of Health and Wellness confirmed Tenant #1 had expressed confusion, though she believed the behavior had only occurred for the past few days. During a subsequent interview on 5/20/26 at 5:05 p.m., the Director of Health and Wellness confirmed she updated Tenant #1's service plan on 5/19/26, but verified she failed to perform any formal evaluation of the tenant's health, functional, or cognitive status to address the progressive change in condition.	A 232		
A 276	481-69.25(1)q Tenant Document 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care	A 276		

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A 276	Continued From page 9 providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks will be part of the medication administration records (MARs); This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure accurate documentation on task sheets and medication administration records (MARs) for 1 of 4 tenants for whom these documents were reviewed (Tenant #1). Findings follow: 1. Record review on 5/19/26 of a 30-day Resident Assessment dated 4/3/26 revealed Tenant #1 received physical therapy and occupational therapy services. An initial service plan signed on 3/2/26 revealed a mandatory directive instructing staff to perform safety checks once per shift, scheduled daily for the 6:00 a.m. to 2:00 p.m. shift, the 2:00 p.m. to 10:00 p.m. shift, and the 10:00 p.m. to 6:00 a.m. shift. Continued record review revealed a Program training document titled "Nurse Delegation for Visual Checks," dated March 2021, revealed staff protocols for conducting safety checks. Instructions required employees to utilize an iPad, go to the tenant ' s apartment, knock on the door, and make direct visual contact with the resident, regardless of whether the tenant was awake or sleeping. Staff were required to log the visual check in the electronic system according to the scheduled time. If a tenant was not inside the apartment, protocols mandated checking throughout the community and notifying other	A 276		

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staff until the person was found. The training document explicitly noted falsification of documentation could lead to counseling or termination.

Further record review on 5/19/26 of the Task Administration Record and electronic care logging system revealed consecutive documentation entries logging Tenant #1 as physically present in the facility:

Staff C documented seeing Tenant #1 during the 10:00 p.m. to 6:00 a.m. shift on 5/11/26.

Staff D documented seeing Tenant #1 during the 6:00 a.m. to 2:00 p.m. shift on 5/11/26.

During an interview on 5/19/26 at 7:12 p.m., Staff B stated he completed evening rounds around 10:00 p.m. on 5/10/26 and heard sounds coming from Tenant #1's apartment. Staff B stated he believed at the time the noise was Tenant #1, though he now believed the sounds came from a radio. Staff B confirmed he did not make direct visual contact or see Tenant #1 at 10:00 p.m. during the evening safety checks, noting the last time he saw her was between 7:00 p.m. and 7:30 p.m.

During an interview on 5/20/26 at 7:12 a.m., Staff C reported he completed safety checks in conjunction with Staff B on 5/10/26. Staff C stated Staff B told him Tenant #1 was inside her apartment at 10:00 p.m., and Staff C entered a visual confirmation entry into the electronic record at 1:06 a.m. on 5/11/26. Staff C verified he never saw Tenant #1 during his shift.

During an interview on 5/20/26 at 10:50 a.m., Staff D stated she did not complete a safety

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A 276	Continued From page 11 check on Tenant #1 during her shift despite documenting the entry. Staff D stated she was actively passing medications to other tenants at the time and assumed her co-workers completed the safety checks. Staff D stated because no one told her Tenant #1 was missing from the building, she logged the tenant as present. During an interview on 5/19/26 at 5:10 p.m., the Director of Health and Wellness stated she received a telephone call from a medical secretary at Tenant #1's Primary Care Provider's office on 5/11/26 at 1:35 p.m. The secretary reported Tenant #1 spent the previous night in a local motel without the knowledge of facility personnel, was at the clinic office, and requested her medication. The Director of Health and Wellness confirmed this telephone call was the first time she became aware Tenant #1 had left the facility. She stated she initially informed the clinic secretary Tenant #1 was safe inside the building and had already received her morning medication because the administration was marked as completed on the MAR. The Director of Health and Wellness stated she initiated an investigation after speaking with Staff D and learning the employee never saw Tenant #1. She noted Tenant #1 had a mild cognitive impairment, making it safe to leave the building with a friend, but noted the tenant was expected to notify staff or sign out. During an interview on 5/20/26 at 12:35 p.m., the Director of Health and Wellness stated staff are trained to check on tenants once per shift, set eyes on residents to ensure safety, and immediately document the visual check using their assigned iPads. She verified the staff person performing the check is solely responsible for entering the documentation.	A 276		

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A 276	Continued From page 12 2. Record review on 5/21/26 of an undated training document titled "Nurse Delegation for Medication Management" revealed the facility standard for medication charting. Instructions directed staff to check medication management times, read the MAR, locate the correct bubble pack, ensure the MAR and bubble pack matched, and recheck the medication label with the MAR. Staff were instructed to initial the MAR and administer the dose. If a tenant refused medication, staff instructions required documenting a medication refusal and immediately notifying the nurse. Record review on 5/21/26 of Tenant #1's April 2026 Medication Administration Record (MAR) revealed a active physician's order for Atorvastatin Calcium 40 milligrams (mg), take one pill orally daily at 8:00 p.m. Review of the MAR verified contradictory, overlapping, and erratic documentation regarding the administration of this medication throughout the month: Staff documented "other" on 4/2, 4/3, 4/6, 4/12, 4/16, 4/19, 4/23, and 4/25 through 4/30, typing written justifications including "didn't see it," "out of stock," and "not available." Staff documented "refused" on 4/4, 4/5, 4/7, 4/8, 4/10, 4/13, 4/15, 4/18, and 4/21. Staff documented the medication was successfully administered to the tenant on 4/1, 4/2, 4/3, 4/4, 4/5, 4/9, 4/11, 4/14, 4/17, 4/20, 4/22, and 4/24. During an interview on 5/21/26 at 9:10 a.m., the	A 276		

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A 276	Continued From page 13 Director of Health and Wellness stated Tenant #1's Atorvastatin Calcium was completely missing from the facility during the entire month of April 2026, making it impossible for staff to administer. The Director of Health and Wellness confirmed the employees who logged the medication as "refused" or "administered" failed to document accurately on the MAR and failed to follow their training protocols.	A 276		
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 with 30 days of admission for 1 of 1 tenants reviewed who moved in within the prior two months (Tenant #1). Findings follow: Record review on 5/19/26 of a Resident Information sheet revealed Tenant #1 moved to the Program on 3/3/26. The Program did not have a service plan completed within 30 days of her admission date.	A 282		

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A 282	Continued From page 14 The Director of Health and Wellness confirmed the Program failed to complete a 30-day service plan for Tenant #1 during an interview conducted on 5/20/26 at 11:30 AM.	A 282		
A 285	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and indicate: 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 individual needs and preferences were included within tenant service plans. This pertained to 2 of 4 tenants whose service plans were reviewed (Tenant #1 and Tenant #4). Findings follow: 1. Record review on 5/21/26 of a Staff Documentation/Communication to Nurse form dated 5/11/26 verified an employee completed written notification morning of 5/11/26, reporting Tenant #1 vocalized a desire to leave the facility and move to a homeless shelter. During an interview on 5/19/26 at 4:40 p.m., Staff A stated Tenant #1 had not been acting like herself for the past month, noting she appeared worried about air quality, purchased two air purifiers, and requested to sleep in different apartments to determine if other rooms had less	A 285		

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A 285	Continued From page 15	A 285		

of an effect on her allergies. Staff A stated her conversations no longer made sense, she wandered around the building, and she slept in a facility model apartment the night of 5/9/26 because she claimed something in her own room made her uncomfortable.

During an interview on 5/20/26 at 7:12 a.m., Staff C reported a progressive change in Tenant #1 over the preceding two weeks, noting she asked to sleep in different apartments and repeatedly requested nocturnal blood pressure checks up to three times per shift. Staff C verified these behaviors were entirely new actions for the tenant.

During an interview on 5/21/26 at 11:45 a.m., Staff E stated Tenant #1 told her on 5/10/26 she wanted to move to a homeless shelter because the Program was stealing her money and making her sick. Staff E stated once she discovered no one could locate Tenant #1 on 5/11/26, she immediately reported the details to the Executive Director and the nurse.

During an interview on 5/20/26 at 7:45 a.m., Staff F stated he observed a distinct change in Tenant #1's behavior over the past week, noting she requested to spend nights in three different apartments, slept in another resident's apartment on one occasion, and claimed her allergies were worse inside her assigned room.

During an interview on 5/20/26 at 10:10 a.m., Staff G stated Tenant #1 appeared increasingly confused lately compared to when she initially moved to the Program two months prior. Staff G stated she refused to sleep in her bed due to a belief something was wrong with it, vocalized she was unable to remain in the building, and

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A 285	Continued From page 16 appeared to be distancing herself from everyone. During an interview on 5/19/26 at 5:10 p.m., the Director of Health and Wellness stated she received a telephone call from a medical secretary at Tenant #1's Primary Care Provider's office on 5/11/26 at 1:35 p.m., alerting her the tenant spent the previous night in a motel, was currently at the clinic office, and requested medication. The Director of Health and Wellness confirmed this telephone call was the first time she became aware Tenant #1 was gone from the building. During a subsequent interview on 5/26/26 at 11:47 a.m., the Director of Health and Wellness reported Tenant #1 requested to have her blood pressure checked daily beginning on 4/3/26 because she became hyperfixated on the measurement. Record review on 5/21/26 of Tenant #1's service plan dated 5/19/26 revealed the document specified she did not display wandering behavior and did not exhibit past or present behavior issues. The service plan directed staff to take her blood pressure daily and report abnormal readings to the nurse, but completely lacked documentation addressing her complex behavioral needs. During an interview on 5/20/26 at 11:30 a.m., the Director of Health and Wellness stated she updated Tenant #1's service plan on 5/19/26. She confirmed the updated service plan failed to provide staff with specific interventions or list clinical and behavioral concerns relating to her acute allergies, her desire to sleep in various apartments, her requests for multiple nocturnal blood pressure checks, or her verbalized intent to leave the building.	A 285		

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A 285	Continued From page 17 2. Record review on 5/21/26 of a 90-day Resident Assessment dated 4/13/26 for Tenant #4 revealed diagnoses including bilateral blindness. The assessment verified he was incontinent of bowel and bladder, required staff assistance managing the incontinence, and utilized base facility housekeeping services provided once weekly. During an interview on 5/20/26 at 7:45 a.m., Staff F stated it was difficult to keep Tenant #4's bathroom clean due to his severe vision impairment. During an interview on 5/20/26 at 10:10 a.m., Staff G stated Tenant #4 required daily bathroom checks to ensure the area was kept clean and sterilized, noting Staff F had cleaned the bathroom earlier that morning. A physical tour of Tenant #4's apartment was conducted on 5/20/26 at 3:05 p.m. in the presence of the Director of Health and Wellness. A heavy odor was apparent immediately upon entry into the apartment, becoming significantly stronger inside the bathroom. No visible urine or feces was observed in the bathroom at the time of the tour. The Director of Health and Wellness stated the housekeeper generally cleaned the bathroom each morning but did not work every day, adding she frequently thought about methods to keep the bathroom cleaner for Tenant #4. Record review on 5/21/26 of Tenant #4's undated service plan revealed directives identifying he had intermittent incontinence, required staff assistance, and received base housekeeping services on a daily, as-needed basis. Review of	A 285		

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A 285	Continued From page 18 the service plan verified the document completely lacked specific instructions or preferences directing staff to perform the necessary daily bathroom monitoring, sanitization routines, or odor control measures required to support his physical blindness and incontinence. During an exit meeting on 5/21/26 at 3:00 p.m., the Director of Health and Wellness and the Assistant Director of Health and Wellness confirmed the Program failed to ensure these tenants' individual needs and preferences were included within service plans.	A 285		