DEPARTMENT OF INSPECTIONS AND APPEALS ok

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0299	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF DES MOINES MC	5815 SE 27TH STREET DES MOINES, IA 50320

(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: 0 Number of tenants with cognitive impairment: 8 Total census: 8 No regulatory insufficiencies were cited during the investigation of Incident #110136-C. The following regulatory insufficiencies were cited during the investigation of Incident #112424-I.	A 000	See Attached POC 6/25/23	
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 Program failed to consistently ensure staff were trained/delegated within the 30 day of employment. Finding follows: Record review on 4/23/23 revealed the Program hired Staff A 2/26/23 and Staff B on 12/10/23.	A 345		

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A 345	Continued From page 1 Further review revealed the Program failed to complete delegations with/for Staff A. The Program documented Staff B received training/delegations on 1/24/23. When interviewed on 4/24/23 at 1:48 p.m. the Regional Nurse Specialist confirmed the Program failed to complete training/delegations as required.	A 345		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff completed dependent adult abuse training within six months of employment. This pertained to 1 of 2 staff hired within the last six months (Staff B). Finding follows: Chapter 235B.16 requires that employees complete two hours of training relating to the identification and reporting of Dependent Adult Abuse within six months of initial employment and at least two hours of additional dependent adult abuse identification and reporting training every three years thereafter. Record review on 4/23/23 revealed the Program hired Staff B on 12/10/23. No dependent adult abuse training, completed within six months of employment, could be located.	A 380		

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A 380	Continued From page 2 When interviewed on 5/2/23 at 4:00 p.m. the Community Director confirmed the Program failed to ensure Staff B completed her dependent adult abuse training.	A 380		
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 consistently update service plans to meet the tenants needs. This affected 1 of 1 tenant (Tenant #1) reviewed for Incident 112424-I. Finding follows: Record Review on 5/3/23 revealed Incident Reports (IR) for Tenant #1. Review revealed Tenant #1 had fallen three times on 4/6/23. Further review revealed an IR dated 4/6/23 at 6:20 p.m. under immediate action the nurse noted, the service plan updated and directed staff to do visual checks more than eight times a shift, door to remain open and staff to sit at the doorway to have a better visual of Tenant #1. Review of Tenant #1's most recent service plan revealed the Program failed to update the service plan to include the above directions to staff. When interviewed on 5/2/23 at 11:58 a.m. the Regional Nurse Specialist confirmed the Program failed to update Tenant #1's service plan with the	A 395		

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A 395	Continued From page 3 above directions to staff.	A 395		
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. 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 training within 30 days of employment. This pertained to 1 of 2 staff hired in 2023 (Staff A). Findings follow: Record review on 4/24/23 revealed the Program hired Staff A on 2/26/23. Review of dementia-specific training documentation revealed no documentation of dementia- specific education for Staff A. When interviewed on 4/24/23 at 1:48 p.m. the Regional Nurse Specialist confirmed the Program could not located dementia- specific training documentation for Staff A.	A 545		
A 556	481-69.30(3)b Dementia-Specific Education for Personnel 69.30(3) Dementia-specific continuing education b. Direct-contact personnel employed by or contracting with a dementia-specific program or	A 556		

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A 556	Continued From page 4 employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure all staff received eight hours of dementia-specific education annually. This pertained to 2 of 4 staff reviewed (Staff C and D). Findings follow: Record review on 4/24/23 revealed no documentation of dementia specific training for Staff C and D. When interviewed on 4/24/23 at 1:48 p.m. the Regional Nurse Specialist said the Program could not locate any documentation of dementia- specific training documentation for Staff C and D.	A 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0299	DATE SURVEY COMPLETED: 5/3/2023

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 Section** 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 Program failed to consistently ensure staff were trained/delegated within the 30 day of employment	**A345**	**What initial correction was made?** Staff A's delegations were completed on 04/26/2023.	**How will we ensure and maintain compliance going forward?** The Director or Designee will ensure that all requirements are met by utilizing the new employee orientation check list for all new hires. The Director or Designee will audit all new employee files to ensure delegations are in place within 30 days of their hire date monthly, as needed, as determined by the Director/Designee.	Implementation Date: 06/01/2023 Completion Date: On going Responsible Party: Director or designee
Tag #2	**Regulation and Reg Number Section** 481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff completed dependent	**A380**	**What initial correction was made?** Staff B is no longer employed by the community as of 04/30/2023.	**How will we ensure and maintain compliance going forward?** The new Director received training on utilizing the orientation check list. All new hires will complete Dependent Adult Abuse training upon hire. The Director will ensure the new hire orientation checklist is utilized. An audit will be completed on all existing employee files to ensure all training	Implementation Date: 06/01/2023 Completion Date: On Going Responsible Party: Director or designee

	adult abuse training within six months of employment. This pertained to 1 of 2 staff hired within the last six months (Staff B).			requirements have been met by 7/1/2023.	
Tag #3	**Regulation and Reg Number Section** 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 consistently update service plans to meet the tenants needs. This affected 1 of 1 tenant (Tenant #1) reviewed for Incident 112424-I.	**A395**	**What initial correction was made?** Tenant #1's service plan and tasks were updated with all current interventions and tasks. An audit will be completed with each comprehensive assessment to ensure that each resident's ISP and tasks are consistent and up to date by 7/15/2023.	**How will we ensure and maintain compliance going forward?** An audit will be completed by the Director, Nurse, or designee to ensure that Service Plans and Tasks are consistent when a comprehensive assessment is completed weekly, monthly, as needed, as determined by the Director or designee.	Implementation Date: 05/03/2023 Completion Date: On Going Responsible Party: Director or designee
Tag #4	**Regulation and Reg Number Section** 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 training within 30 days of employment. This pertained to 1 of 2 staff hired in 2023 (Staff A).	**A545**	**What initial correction was made?** Staff A completed their Dementia Specific training on 05/16/2023. An audit will be completed by the Director or Designee for all existing employee files to ensure training requirements have been met by 7/15/2023.	**How will we ensure and maintain compliance going forward?** The Director or Designee will ensure that all requirements are met by utilizing the new employee orientation check list for all new hire training. The Director will audit all new employee files monthly, as needed, as determined by the Director/Designee to ensure compliance. All new hires will complete at least 8 hours of Dementia Specific training prior to the completion of their orientation, within their first 30 days of employment.	Implementation Date: 06/01/2023 Completion Date: On Going Responsible Party: Director or designee

Tag#5	**Regulation and Reg Number Section** 481-69.30(3)b Dementia-Specific Education for Personnel 69.30(3) Dementia-specific continuing education b. Direct-contact personnel employed by or contracting with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure all staff received eight hours of dementia-specific education annually. This pertained to 2 of 4 staff reviewed (Staff C and D).	**A556**	**What initial correction was made?** Staff C & D completed eight hours of continuing Dementia training by 6/25/2023.	**How will we ensure and maintain compliance going forward?** The Director/ Designee will have a Staff yearly reminder sheet. The Director/ Designee will make sure staff complete their yearly Dementia training courses before moving forward with their annual reviews.	Implementation Date: 06/01/2023 Completion Date: On Going Responsible Party: Director 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: 7/7/2023