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 |
|---|---|---|---|
| | S0299 | A. BUILDING: _____ B. WING _____ | C 03/23/2026 |

| 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<br><br>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.<br><br>Tenants without cognitive impairment: 0<br>Tenants with cognitive impairment: 14<br>Total census: 14<br><br>The following regulatory insufficiencies were cited during the investigation of Incident #143085-I. | A 000 | See attached POC 5/29/26 | |
| A 116 | 481-67.2(2) Program Policies and Procedures<br><br>67.2(2) The program shall follow the policies and procedures established by the program.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the Program failed to follow established policy and procedure regarding Missing Persons Elopement for 1 of 1 tenants (Tenant #1) who eloped from the Program. Findings follow:<br><br>Record review on 3/19/26 revealed Tenant #1 admitted to the Program on 6/16/25 and currently resided in the locked/secured memory care unit. Tenant #1's diagnoses included unspecified dementia, anxiety disorder, other insomnia, glaucoma, essential (primary) hypertension, and age-related osteoporosis. A 90-day assessment, dated 1/23/26, noted Tenant #1 required regular prompting due to confusion and disorientation, but was independent with mobility and used a cane and/or walker as an assistive device. Tenant #1 had a Global Deterioration Score of six, indicating severe cognitive decline. | A 116 | | |

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 |
|---|---|---|---|
| | S0299 | A. BUILDING: _____ B. WING _____ | C 03/23/2026 |

| 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 116 | Continued From page 1<br><br>Record review on 3/19/26 revealed an elopement incident report, dated 3/17/26, indicated Tenant #1 eloped from the Program after exiting the memory care west door at 4:19 a.m. Tenant #1 was observed approximately eleven minutes later at 4:30 a.m., and attempted to shake the memory care south door to gain entry. A door alarm report confirmed these door alarms and times.<br><br>Review on 3/19/26 of staff written statements from the Program's internal investigation revealed:<br><br>a. Staff A's 3/17/26 statement noted she had been on duty in the memory care unit at the time of the elopement. Staff A sat in the dining room charting when the door alarm sounded. Staff A indicated she thought the alarms were caused by someone trying to break into the building. Staff A called Staff B who was working on the assisted living side of the building to go with her to check the door. Staff B would come after contacting another staff member to also come investigate. Staff A looked down the hall to see if any residents were present, but didn't notice any residents.<br><br>b. Staff B's 3/17/26 statement noted the memory care west door alarm sounded on the alert app and Staff A called her frightened due to the alarm and concerned a stranger might be at the door. Staff B indicated upon entering the memory care hall entrance, they turned to head toward the west door where the alarm was sounding and observed an individual outside near the memory care south door. Staff B noted they approached and identified it was Tenant #1 who was outside and attempted to gain entry to the building. Tenant #1 was without a coat and without her walker, but did have her cane. | A 116 | | |

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 |
|---|---|---|---|
| | S0299 | A. BUILDING: _____ B. WING _____ | C 03/23/2026 |

| 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 116 | Continued From page 2<br><br>c. Staff C's 3/17/26 statement noted she was contacted at 4:36 a.m. by Staff A who reported the incident. Staff C indicated Tenant #1 was reported to have been dressed in jeans, shirt, and shoes. Tenant #1 denied any discomforts and no injury was noted.<br><br>During a phone interview on 3/19/26 at 2:40 p.m., Staff A reported she sat in the dining room charting when the alarm sounded. Staff A stated "I know I'm supposed to go to the area (of the alarm) to check", but indicated she didn't even think it could be Tenant #1 as she never attempted to exit-seek before. She last saw Tenant #1 during the 4:00 a.m. rounds and noticed Tenant #1 was awake and watching tv with the lights off in her room. Staff A feared someone was attempting to break into the building. Staff A acknowledged she got up and looked down the south hallway from the dining room, but didn't go down the hallway to the west door to check the door. Staff A acknowledged per the Program's policy she was supposed to go down the hall, check the alarm, check and see if any tenants were there or in the general area, and then clear the code. Review of the delegation form on Door Alarm Response revealed Staff A had been trained on the procedural steps on 12/02/25.<br><br>During an interview on 3/19/26 at 1:45 p.m. with the Executive Director (ED) while on tour of the memory care unit and review of the Program's doors related to the incident, the ED acknowledged Staff A failed to check the west door and investigate the cause of the alarm, or check outside the door. The ED acknowledged Staff A did not begin to account for the tenants per the Program's policy. The ED had prepared | A 116 | | |

| 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 03/23/2026 |

| 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 116 | Continued From page 3 | A 116 | | |

disciplinary action for Staff A. The ED indicated the Program revised Tenant #1's service plan to include a risk for wandering and added a wanderguard bracelet for Tenant #1.

On 3/19/26, the State Climatologist provided a weather conditions report for the date and timeframe of the elopement incident. The temperature on 3/17/26 was noted nine degrees Fahrenheit with wind chills in the range of negative three to four degrees. Winds were out of the northwest at eight to nine miles per hour, with fair conditions.

A review on 3/19/26 of the Program's Missing Person Elopement policy, dated 6/13/24, directed staff to immediately respond to the door alarms and/or other monitoring alert systems. The policy further directed all tenants in the secured area needed to be accounted for starting with the wandering risk list immediately if no tenant was found near the door. Staff also searched the immediate area to ensure no other tenants eloped unnoticed.

A review on 1/23/26 of the disciplinary action form for Staff A noted "(Staff A) did not make any immediate attempt to visually check the door or assess whether a resident had exited while the alarm was active" and "(Staff A's) failure to respond promptly to the door alarm and assess the situation resulted in a resident being unsupervised outside in unsafe conditions." The disciplinary form noted Staff A had failed to follow established safety protocols.

On 1/23/26 at 4:05 p.m., the Executive Director confirmed the above findings.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0299 | DATE SURVEY COMPLETED: 03/23/2026 |
|---|---|---|

| 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 A116** | **481-67.2(2) Program Policies and Procedures**<br><br>**67.2(2) The program shall follow the policies** and procedures established by the program.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the Program failed to follow established policy and procedure regarding Missing Persons Elopement for 1 of 1 tenants (Tenant #1) who eloped from the Program. | **A116** | **What initial correction was made?**<br><br>Education was provided immediately to Staff A, Staff B, and Staff C on Elopement policy and procedures. Staff A is no longer employed with the Community. | **How will we ensure and maintain compliance going forward?**<br><br>All current and new employees will receive ongoing education regarding our Elopement Policies and Procedures. Elopement Drills will continue to be completed routinely by Ed or designee. All Staff will be re-educated on the current policies and procedures for Elopements by 5/29/2026 | Implementation Date: 5/12/2026<br><br>Completion Date: On Going<br><br>Responsible Party: Ed 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: 10/4/2024