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
	S0347	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEN PLACE	1406 EAST 19TH STREET ATLANTIC, IA 50022

(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 are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment:19 Number of tenants with cognitive impairment: 17 Total census:36 This Program has met criteria to be an Assisted Living Program for People with Dementia by definition for this certification period. No regulatory insufficiencies were cited during the investigation of Complaints #118038-C and 123706-C. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program	A 000		
A 400	481-67.19(3) Record Checks 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 400		

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
	S0347	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEN PLACE	1406 EAST 19TH STREET ATLANTIC, IA 50022

(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 400	Continued From page 1 Program failed to consistently perform criminal background checks prior to employment. This pertained to 1 of 2 staff reviewed (Staff A). Finding follows: Record review on 10/30/24 revealed the Program hired Staff A on 8/19/24. The Program provided a SING (Single Contact Registry) dated 10/30/24. When interviewed on 10/30/24 at 3:30 p.m. the Executive Director confirmed the Program failed to complete the SING prior to employment of Staff A.	A 400		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure service plans were based on evaluations (cognitive, functional and health). This pertained to 4 of 4 tenants reviewed(Tenant #1 - #4). Finding follows: 1. Record review on 11/4/24 revealed the following regarding service plans:	A 350		

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
	S0347	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEN PLACE	**1406 EAST 19TH STREET ATLANTIC, IA 50022**

(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 350	Continued From page 2 Tenant #1's service plan was dated 9/26/24. The Program completed a cognitive evaluation dated 9/24/24. No health and functional evaluations were provided by the Program. Tenant #2's service plan was dated 5/23/24. The Program completed health, functional and cognitive evaluations on 3/1/24, which was approximately 11 weeks before the service plan was developed. Tenant #3's service plan was dated 7/3/24. The Program completed health and functional evaluations on 5/9/24 and a cognitive evaluation on 5/8/24, which was approximately 7 weeks before the service plan was developed. Tenant #4's service plan dated was 10/2/24. The Program completed health and functional evaluations on 8/2/24 (2 months before the service plan) and a cognitive evaluation on 8/14/24 (approximately 6 months before the service plan was developed). 2. On 11/4/24 at 5:09 p.m. the Director confirmed the Program had provided all documentation related to evaluations and service plans.	A 350		