

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/28/2026
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

THE KENSINGTON

STREET ADDRESS, CITY, STATE, ZIP CODE

**2210 AVENUE H
FORT MADISON, IA 52627**

(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: 46 Number of tenants with cognitive impairment: 1 Total census: 47 The following regulatory insufficiencies were cited during the investigation of Complaint #131292-C.	A 000		
A 355	481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure an initial service plan was signed and dated by all parties for 1 of 3 tenants reviewed (Tenant #1). Finding follows: Record review on 1/27/26 revealed Tenant #1 admitted to the Program on 1/08/26. Review of	A 355		

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: S0381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/28/2026
NAME OF PROVIDER OR SUPPLIER THE KENSINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 AVENUE H FORT MADISON, IA 52627		
(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 355	Continued From page 1 the service plan provided by the Program revealed a print date of 1/27/26, but failed to be signed or dated by either Tenant #1 or a representative of the Program. During an interview on 1/28/26 at 11:00 a.m., the Director of Nursing (DON) indicated she was unable to locate a signed/dated service plan within their electronic records system and going forward she would print out hard copies of the service plans for all tenants to sign and date. During an interview on 1/28/26 at 11:50 a.m., the Executive Director (ED) indicated the Program's support contact from their electronic records system had not responded to their requests for assistance in accessing the digitally signed/dated service plans and thus would be unable to provide them. The ED reported going forward the Program would no longer rely on the digital signatures, but rather print off the service plans for all tenants to sign and date. On 1/28/26 at 2:00 p.m., the Executive Director and Director of Nursing confirmed the above findings.	A 355		
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.	A 370		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/28/2026
NAME OF PROVIDER OR SUPPLIER THE KENSINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 AVENUE H FORT MADISON, IA 52627		
(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 370	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure the service plans related to significant change were signed and dated by all parties for 1 of 3 tenants reviewed (Tenant #2). Findings follow: Record review on 1/28/26 revealed Tenant #2 admitted to the program on 10/04/25. The Program completed a comprehensive evaluation on 11/10/25 for the purpose of discontinuing some services. A corresponding service plan was signed and dated by the Director of Nursing on 11/10/25, but failed to be signed and dated by Tenant #2. During an interview on 1/28/26 at 11:00 a.m., the Director of Nursing (DON) indicated she was unable to locate a signed/dated service plan within their electronic records system and going forward she would print out hard copies of the service plans for all tenants to sign and date. During an interview on 1/28/26 at 11:50 a.m., the Executive Director (ED) indicated the program's support contact from their electronic records system had not responded to their requests for assistance in accessing the digitally signed/dated service plans and thus would be unable to provide them. The ED reported going forward the program would no longer rely on the digital signatures, but rather print off the service plans for all tenants to sign and date. On 1/28/26 at 2:00 p.m., the Executive Director and Director of Nursing confirmed the above findings.	A 370		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/28/2026
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE KENSINGTON

**2210 AVENUE H
FORT MADISON, IA 52627**

(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