

ok

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/03/2023
NAME OF PROVIDER OR SUPPLIER ADDINGTON PLACE OF DES MOINES		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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: 7 Number of tenants with cognitive impairment: 12 Total census: 19 No regulatory insufficiencies were cited during the investigation of Incidents #107814-I, 111973-I and Complaint 112314-C. The following regulatory insufficiencies were cited during the investigation of 110197-C	A 000	See Attached POC 7/7/23	
A 175	481-67.3(5) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67/3(5) To receive from the manager and staff of the program a reasonable response to all requests. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the Program failed to consistently provide a response to requests. This pertained to 1 of 3 tenants (Tenant #1) reviewed during complaints 112341-C and 110197-C. Finding follows: During an interview on 4/20/23 at 2:35 p.m. the interviewee expressed concerns regarding a functioning mailbox key. When interviewed on	A 175		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE **Director**

(X6) DATE

6/22/23

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/03/2023
NAME OF PROVIDER OR SUPPLIER ADDINGTON PLACE OF DES MOINES		STREET ADDRESS, CITY, STATE, ZIP CODE 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 175	Continued From page 1 5/2/23 at 4:00 p.m. the Program's management said all tenants had functioning mailbox keys. According to the interviewee on 4/20/23 the Program has not addressed her concern regarding a functioning mailbox key since her husband moved two years ago.	A 175		
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).	A 345		
	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. 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.			

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/03/2023
NAME OF PROVIDER OR SUPPLIER ADDINGTON PLACE OF DES MOINES		STREET ADDRESS, CITY, STATE, ZIP CODE 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 380	Continued From page 2	A 380		
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. 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		