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
	S0417	A. BUILDING: _____ B. WING _____	C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF DES MOINES	**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: 37 Number of tenants with cognitive impairment: 1 Total census: 38 No regulatory insufficiencies were cited during the investigation of Complaints #117118-C and 117120-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	The Plan of Correction is attached.	
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure tenants received medications as prescribed. This pertained to 1 of 1 tenants reviewed with a prescription for pain medication (Tenant #2). Finding follows:	A 285		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 285	Continued From page 1 Observations and record review on 8/6/24 at 1:00 p.m. revealed staff checked Tenant #2's medication administration record (MAR) and noted Tenant #2's Hydroco/APAP (hydrocodone 5mg-acetaminophen 325mg) could not be located. She noted medication not available on the MAR. While administering other medications, staff asked Tenant #2 to rate her pain level. Tenant #2 rated her pain as a six on a scale of 1 - 10, 1 being least amount of pain and 10 being the highest level of pain. Review of Tenant #2's August MAR on 8/6/24 revealed Program staff failed to administer medications as ordered. Examples include but were not limited to the following: Hydroco/APAP tab 5-335 mg 1/2 tablet by mouth three times daily: 8/4/24 at 8:00 a.m., 2:00 p.m. and 8:00 p.m. 8/5/24 at 8:00 a.m., 2:00 p.m. and 8:00 p.m. 8/6/24 at 8:00 a.m., 2:00 p.m. Further review revealed the staff documented medication not available for the above examples. During the exit on 8/7/24 at 3:15 p.m. the administrative staff confirmed the Program had failed to ensure the medication was available and administered to Tenant #2.	A 285		
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	A 400		

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A 400	Continued From page 2 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 Program failed to consistently perform criminal history and abuse background checks as required prior to employment. This pertained to 2 of 4 staff reviewed (Staff A and B). Finding follows: Record review on 8/7/24 revealed the Program hired Staff A on 3/26/24. The Program provided a background check completed by a national background screening agency on 3/7/24. Neither a review of her criminal history by the department of public safety or a child and dependent adult abuse check by the department of health and human services was provided. Record review on 8/7/24 revealed the Program hired Staff B on 12/27/23. The Program provided a SING (Single Contact Registry) form for Staff B. The SING was completed on 12/29/24, two days after the staff was hired. On 8/7/24 at 3:15 p.m. the administrative team confirmed the Program failed to complete required record checks prior to employment for Staff A and B as required.	A 400		
A 390	481-69.26(3)e 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 390		

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A 390	Continued From page 3 e. The service plan shall be reviewed, updated if necessary, and signed and dated by all parties at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure services plans were signed and dated as required. This pertained to 2 of 4 tenants reviewed (Tenant #1-2). Finding follows: Record review on 8/6/24 revealed Tenant #1's last service plan review was completed on 6/7/24. Both Tenant #1 and the Executive Director signed the service plan but neither included the date. Further review revealed Tenant #2's last service plan review was completed on 4/4/24. The Program failed to obtain signatures with dates for Tenant #2's service plan. During the exit on 8/7/24 at 3:15 p.m. administrative staff acknowledged the Program failed to ensure service plans were dated and signed as required.	A 390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0417	DATE SURVEY COMPLETED: 8/7/2024

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	**481-67.5(2)f(4) Medications 67.5(2)** Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: A 285 Based on interview and record review the Program failed to ensure tenants received medications as prescribed. This pertained to 1 of 1 tenants reviewed with a prescription for pain medication (Tenant #2).	**A285**	**What initial correction was made?** All Medication Delegated staff received training on MAR documentation, notifying nurses when medications are unavailable and re-ordering medications through pharmacy.	**How will we ensure and maintain compliance going forward?** Audit three residents 1x weekly x 4 weeks to ensure medications are available and document correctly. Then DHW/Designee utilize as needed going forward. DHW or Designee will continue to provide training on MAR documentation, notifying nurses when medications are unavailable and re-ordering medications through pharmacy with all new Med delegated staff members and Quartey.	Implementation Date: 10/04/2024 Completion Date: On going Responsible Party: DHW or designee
Tag #2	**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 Program failed to consistently perform criminal history and abuse background checks as required prior to employment. This pertained to 2 of 4 staff reviewed (Staff A and B).	**A400**	**What initial correction was made?** SING background check was run on Staff A 8/7/2024.	**How will we ensure and maintain compliance going forward?** The Director or Designee will ensure that all requirements are met by utilizing the Pre-employment check list for all new prospective employees before allowed to start employment/start working. The Director or Designee will audit all new employee files to ensure Pre-employment requirements were met.	Implementation Date: 08/07/2024 Completion Date: On Going Responsible Party: Director or designee

Tag #3	**481-69.26(3)e 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 ess than annually. e. The service plan shall be reviewed, updated if necessary, and signed and dated by all parties at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure services plans were signed and dated as required. This pertained to 2 of 4 tenants reviewed (Tenant #1-2).	**A390**	**What initial correction was made?** Education was provided to the DHW on proper procedures on service plans reviews, signatures and dates.	**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 are signed and dated as required when a comprehensive assessment is completed weekly, monthly, as needed, as determined by the Director or designee.	Implementation Date: 10/04/2024 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.

✓ 3.31.25

Compliance Date: 10/4/2024