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
	S0433	A. BUILDING: _____ B. WING _____	03/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDLY HORIZONS, LLC	645 1ST AVENUE SW SIOUX CENTER, IA 51250

(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 for People with Dementia 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 disorder: 0 Number of tenants with cognitive disorder: 7 TOTAL census of Assisted Living Program for People with Dementia: 7 The following regulatory insufficiencies were cited during the initial certification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia. No regulatory insufficiencies were cited during the onsite infection control survey.	A 000	See Attached POC 4/1/21	
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 Program failed to complete criminal, child, and dependent adult abuse background checks prior to employment for 3 of 6 staff reviewed (Staff A, Staff B, and Staff C). Findings follow:	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
	S0433	A. BUILDING: _____ B. WING _____	03/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDLY HORIZONS, LLC	645 1ST AVENUE SW SIOUX CENTER, IA 51250

(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 1. Review of Staff A's file on 3-10-21 revealed a hire date of 3-23-2020. A Single Contact License and Background Check was completed 4-24-2020 2. Review of Staff B's file on 3-10-21 revealed a hire date of 8-10-2020. A Single Contact License and Background Check was completed 3-10-21. 3. Review of Staff C's file on 3-10-21 revealed a hire date of 5-26-2020. A Single Contact License and Background Check was completed 6-9-2020. The Administrator confirmed these findings on 3-10-21 at 3:22 p.m.	A 400		

645 1st Ave SW Sioux Center, IA 51250

Plan of Correction

1. Elements detailing how the Program will correct each regulatory insufficiency; including at the system level.

   All background checks including but not limited to Criminal, child and dependent abuse will be performed on every single person prior to employment with the facility with SING.

2. Measures taken to ensure the problem does not recur.

   The program administrator will ensure that these items are completed by their tentative hire date to avoid any insufficiencies in the future.

3. How the Program plans to monitor performance to ensure compliance.

   An employee cannot begin working until the background checks have been completed and have been deemed appropriate by the state of Iowa to be employed.

4. The date by which the regulatory insufficiency will be corrected.

   This process has been corrected as of April 1, 2021.