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
	S0446	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE MEMORY SUPPORT	**2479 RIVER ROAD DECORAH, IA 52101**

(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 population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 0 Number of tenants with cognitive impairment: 11 Total census: 11 The following regulatory insufficiency was cited during the investigation of Complaint #123599-C.	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, Program staff failed to follow the policy titled Accident, Incident, and Medication Error Reporting for 1 of 4 discharged tenants reviewed (Tenant C2). Findings include: 1. On 3/5/25, a review of Tenant C2's record revealed diagnoses of mild cognitive impairment of an unknown origin, heart blockage, pacemaker, and congestive heart failure. Tenant C2's service plan dated 9/3/24 revealed due to anticoagulant therapy, Tenant C2's family was responsible for conducting International Normalized Ratio (INR) testing as needed to provide data for the physician to determine what level of Warfarin would be ordered and for what time frame. Tenant C2's physician's orders for	A 150	The Plan of Correction is attached.	

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

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A 150	Continued From page 1 Warfarin revealed he was to take a 2 mg tablet orally once in the evening on Tuesday, Wednesday, Thursday, Friday and Sunday from 8/16/24 through 8/22/24. An order dated 8/16/24 showed Tenant C2 was to have a new INR test on 8/23/24 to determine a new Warfarin prescription. An incident report dated 8/27/24 revealed Staff B discovered Tenant C2 had no Warfarin to take on 8/27/24 and no order was noted on the medication administration record (MAR). Staff B notified the family and requested they contact the physician to get a one time dosage for the night. The family obtained an order for one 3 mg tablet of Warfarin to be taken on 8/27/24. The family informed Staff B the family would come on 8/28/24 to complete INR testing to report to the physician. A progress note written dated 8/27/24 by the Director indicated Tenant C2 had not received any Warfarin between the dates of 8/23/24 and 8/26/24 due to no INR testing being completed by the family on 8/23/24 and no new orders received. The progress note indicated Tenant C2's daughter in law usually completed the INR testing but was on vacation. The Director was also off during this time frame. The daughter in law tested Tenant C2's INR on 8/28/25 and new orders were subsequently received. 2. On 3/5/25 at 9:10 am, Staff B stated Tenant C2's daughter in law came to the Program and tested his INR with her own machine. The daughter in law then then called the clinic nurse to report the INR number and new Warfarin orders were sent to the Program. Staff B stated when she worked on 8/27/24 she was told by a staff member there was no Warfarin to give to Tenant C2 because his INR was not tested by	A 150		

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A 150	Continued From page 2	A 150		

family on 8/23/24. Staff B stated she contacted the family to call the physician and request Warfarin. The family stated they would contact the physician for a one day order and would test Tenant C2's INR on 8/28/24.

3. On 3/5/25 at 9:20 am, the Director stated the INR levels were managed by the daughter in law. The daughter in law was a registered nurse and had a personal machine to test INR levels. The Director noted she would test the INR and call it into the clinic and the Program would receive new orders. On 8/23/24, Tenant C2 was to receive INR testing per physician's orders which were on file in Tenant C2's chart. The Director stated both she and the daughter in law were gone from 8/23/24 through 8/27/24 and the INR testing was not completed on 8/23/24. The Director stated she was notified by Staff B on 8/27/24 that Tenant C2 had no Warfarin to give so she contacted the family to request a one day dose until Tenant C2's INR could be tested on 8/28/24.

4. On 3/6/25 at 1:45 pm, Staff A stated she worked the pm shift on 8/23/24 which was when Tenant C2 normally had his Warfarin administered. She knew Tenant C2's family had not tested his INR on 8/23/24 but was not sure why. She believed there was nothing staff could do about that due to it being the family's responsibility. Staff A had not completed an incident report/medication error report or contacted the nurse in order for her to contact the physician.

5. On 3/5/25, the Program's policy titled Accident, Incident, and Medication Error Reporting was reviewed. The policy indicated the purpose was to ensure prompt and appropriate medical care, notification, and follow-up of medication errors.

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A 150	Continued From page 3 Tenant accidents, incidents, and medication errors were to be documented using the incident report form. When the tenant delegates medication administration to the Program, medication errors will be reported to the physician by the nurse. 6. On 3/6/25 at 2:00 pm, the Director confirmed Staff B who knew the INR testing had not been completed on 8/23/24 should have completed an incident report/medication error report and notified the nurse so that she could have contacted the physician instead of the error being caught by a second staff 4 days later on 8/27/24 allowing Tenant C2 to go 4 days with no Warfarin.	A 150		

Wellington Place
assisted living
kind · compassionate · care

Department of Inspections and Appeals
Attn: Catie Campbell
6200 Park Avenue Suite 100
Des Moines, Iowa 50321

Dear Ms. Campbell:

On behalf of Wellington Place ALPD I respectfully submit our Plan of Correction for your approval. This response is specific to the compliant Complaint #123599-C Visit, for the onsite visit 3/6/2025. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusions set forth in the statement of insufficiencies. The Plan of Correction is executed solely because it is required by the provisions of Iowa Law.

481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program.

1. Elements detailing how the Program will correct each regulatory insufficiency
    - Tenant's receiving medication/treatments assistance shall follow the program's established policy for accident, incident, and medication error reporting.
2. Measures taken to ensure the problem does not recur
    - The Director of Nursing was re-educated on the program's policy for accident, incident, and medication error reporting.
    - The program staff were re-educated, regarding the program's policy for accident, incident, and medication error reporting.
3. How the Program plans to monitor performance to ensure compliance
    - The Director of Nursing and/or Designee will complete ongoing audits to ensure medications are being administered as ordered by the physician, advanced registered nurse practitioner or physician assistant and the program is following established policy for accident, incident, and medication error reporting.
4. The date by which the regulatory insufficiency will be corrected

Wellington Place
assisted living

4. The date by which the regulatory insufficiency will be corrected
   - The regulatory insufficiency will be corrected on or before 4/25/25

If you have any questions regarding this plan of correction, please contact me at **563-382-2292**.

Respectfully submitted,

Mary Miller, RN
Director of Assisted Living
Wellington Place

2475 River Road | Decorah, IA 52101-7596
Nursing Home: (563) 382-9691 | Assisted Living: (563) 382-2292 | Fax: (563) 382-6330