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
	S0170	A. BUILDING: _____ B. WING _____	C 07/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF FAIRFIELD	3000 WEST MADISON AVENUE FAIRFIELD, IA 52556

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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. Tenants without cognitive impairment: 30 Tenants with cognitive impairment: 10 Total census: 40 The following regulatory insufficiencies were cited during the investigation of Complaint #131442-C and Complaint #131535-C.	A 000	See attached POC 9/30/26	
A 122	481-67.3(2) Tenant Rights 481-67.3(231B,231C,231D) Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services that are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to provide 1 of 5 current tenants reviewed (Tenant #5) and 1 of 3 discharged tenants reviewed (Tenant C3) with adequate treatment. Findings follow: 1) Record review on 6/29/26 of a physical exam for Tenant #5 dated 4/3/26 revealed she was a 77-year-old female who presented to the appointment in a wheelchair. She had a medical history of Type II diabetes, osteoarthritis, pressure ulcer, encephalopathy, severe rhabdomyolysis and hyperkalemia. A Tenant list provided by the	A 122		

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A 122	Continued From page 1 Executive Director noted Tenant #5 moved to the program on 3/27/26. Among the prescription orders at the time of admission was: Econazole Nitrate Cream 1%, apply to sacrum every day shift for Stage III to sacrum. Cover with Mepilex. The Program Nurse Practitioner (NP) signed the orders on 3/30/26. Tenant #5 met with the NP on 4/16/26 for treatment of excoriation to the bilateral groin folds and abdominal fold. Her incontinence and extensive wheelchair use were contributing factors to the development of skin breakdown in the groin and abdominal fold areas. The presence of a stage two pressure wound to the intergluteal fold indicated tissue damage requiring specialized wound care management. A ROHO air cushion would be beneficial for pressure distribution given her wheelchair dependence and existing wound which would aid in the healing of the pressure ulcer. She encouraged frequent changing of the incontinence briefs and movement to help with offloading. On 4/27/26, Tenant #5 began receiving services from an agency which provided skilled nursing (wound treatment), occupational therapy (OT) and physical therapy (PT). A review of Progress notes from the Skilled Nurse (SN), Outside Agency Documentation forms, Provider Visit forms and an After Visit Summary for Tenant #5 revealed the following: 5/7/26: The SN noted a pressure ulcer to the coccyx was resolved. 5/12/26: OT identified staff should continue to position her in the recliner and out of wheelchair every couple of hours. Keep encouraging activities to decrease behaviors.	A 122		

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5/12/26: The SN charted she received a call from staff at the Program notifying her Tenant #5 had a weeping, open area and because they could not provide wound care they needed the SN to see the patient that day. She was sitting in a recliner with her legs minimally elevated. She had a small open area to the middle inner calf which was bumped resulting in the skin opening. Due to Tenant #5's leg swelling, the area would continue to weep until the edema decreased (pitting edema of +3 to the RLE and +2 to the LLE). The SN reported the wound to the tenant's Primary Care Provider (PCP) and she provided orders: apply foam dressing after applying skin prep to peri wound on left inner and posterior lower leg weeping areas and change at least every 3-5 days or until saturated with drainage. The PCP prescribed TED hose to reduce Tenant #5's edema. The SN documented the Program employee told her she wasn't allowed to ask Tenant #5 if she was hurting and pain medication could only be administered if a tenant requested it. A previous nurse told the employee Lortab or Tramadol could be ordered by the PCP. The SN asked if Tylenol was easing Tenant #5's pain and the employee reported she hadn't given this medication because it did not work. The SN was unsure of how the determination was made the Tylenol did not work.

5/18/26: The SN documented she was at the Program due to edema to Tenant #5's bilateral lower extremities and weeping open areas. She asked staff to watch for bunching areas on the TED hose around the top of the foot and bottom of the leg to prevent pressure. Skilled nursing visits would increase as the wounds increased from 1 to 3. Foam dressings were applied. If drainage was coming out around the dressing it should be removed. The SN provided this health

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information to Tenant #5's PCP who instructed the tenant to go to a walk-in clinic for medication to reduce the edema as the wounds would not heal and more could develop as long as the swelling remained in her legs (pitting edema of +3 in her right leg and +4 in her left leg).

5/20/26: An After Visit Summary report from the Emergency Room noted Tenant #5 was seen in the Emergency Room due to lip swelling. She was to discontinue the medication Tramadol and start taking Clairitin and Prednisone for 5 days. She should use cool compresses for 15 minutes several times daily and have close primary care follow-up.

5/21/26: The OT directed staff to have Tenant #5 get out of her wheelchair and change positions every couple of hours. She should sit in her recliner with the air cushion throughout the day.

5/28/26: When the SN met with Tenant #5 she continued to experience pitting edema in her legs (+2 in her right leg and +4 in her leg leg but all wounds to her legs were resolved. The SN talked with the Executive Director (ED) about the need for Tenant #5 to obtain a pressure relieving cushion for her wheelchair as this is where she spent most of her time. The ED explained sometimes the patient became upset and combative if she didn't want to get out of the wheelchair. The SN explained a cushion, preferably a ROHO cushion, was the best option to prevent pressure areas from continuously occurring. The SN told the ED she educated the staff last week to stand Tenant #5 up for 30 - 60 seconds to restore blood to her tissue about every hour. The ED then told the SN Tenant #5 had another red area on her right buttock but it wasn't open. The SN said she would observe

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and measure it next week as the treatment would not change from what was previously applied to her buttocks.

6/4/26: Tenant #5 met with the SN and had pitting edema of +4 to her left and right leg. The SN took her to the bathroom to observe the wound and found her incontinence brief was extremely wet. There was a new pressure area over her Ischial tuberosity which staff were to cleanse with a wound cleanser and iodine two times weekly and cover with foam dressing until healed. It measured 3.7 cm x 2.4 cm x 0.1 cm. The SN discussed with staff on the unit the need to keep Tenant #5 as dry as possible and to place in seating other than her wheelchair such as bed. She reminded the ED and ARNP Tenant #5 would continue to have skin breakdown until she got a ROHO cushion for her wheelchair. The ED reported it was difficult to get in contact with Tenant #5's family but they were aware of the need to purchase the cushion.

6/8/26: The SN visited Tenant #5 and provided a number of directives: Wound care provided and covered with a transparent dressing which was waterproof. Staff should leave it on unless it was soiled. Tenant #5 needed to walk three times a day, preferably with shoes or slippers on but per the Physical Therapist it was not worth it if she was refusing. Please walk from her apartment to the dining area or dining room to the toilet. Her urine smelled strong. Encourage fluids. The PCP's office was contacted to write a prescription for a wheelchair cushion.

6/17/26: Tenant #5 needed to be seen by a podiatrist for a foot assessment. SN again documented the wound was worsening as there was 90% slough tissue and 10% granulation

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tissue. Staff reported they applied Econazole Cream twice daily and as needed to her buttocks (it was ordered once every morning). She would be discharged from skilled nursing the following week.

6/22/26: When discharged from Physical Therapy, Occupational Therapy and Skilled Nursing on 6/22/26, the SN noted she was saturated with urine and itching in the perineal area. She needed to be cleaned well in all areas that came in contact with urine. She was itching under her breasts and could use corn starch, baby powder or Nystatin to treat this. The wound on her buttocks measured 3.3 x 1.5. She was not wearing TED hose. Staff should moisturize her lower extremities but not between her toes. All staff should assist her with walking three times daily and provide toileting assistance every two hours. She should stand up for once minute every hour if she was not walking. In order to prevent the condition from worsening she needed to wear compression stockings and get a cushion for her wheelchair.

A review of the Task Administration Record for Tenant #5 for the months of April, May and June, 2026 revealed a task for staff to apply TED hose or lotion to her legs was not included. The task for mobility noted employees needed to escort or push her wheelchair because of a physical limitation. She was able to pedal herself around independently. No changes were made directing staff to have her stand or walk with staff. April 1, 2026 - June 8, 2026, staff were to assist Tenant #5 with removing her clothing and/or incontinence products, onto the toilet and with personal cleaning tasks as needed at 7:00 AM, 10:00 AM, 1:00 PM, 4:00 PM, 7:00 PM, 10:00 PM and as needed. The Task Administration Record was

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updated in the area of toileting assistance on 6/9/26 so staff would provide toileting cares at different times: 5:00 AM, 9:00 AM, 1:00 PM, 6:00 PM, 10:00 PM and as needed. Staff were taking Tenant #5 to the toileting every three hours during waking hours from 4/1/26 - 6/8/26. The task of toileting was changed to every 4-5 hours on 6/9/26. When the SN encouraged staff to take her to the toilet every 2 hours on 6/22/26, no change was made to the task sheet (as of the review on 6/28/26).

Observations on 6/24/26 at 12:18 PM revealed Tenant #5 at lunch. She sat in her wheelchair without a cushion on the seat. During a tour of Tenant #5's apartment on 6/25/26 at 2:45 PM when accompanied by Staff D the medication Econazole Nitrate Cream 1% was on her sink. Staff D had witnessed other staff apply the cream to Tenant #5's buttocks after toileting but she did not do so as she wasn't a certified medication manager. The prescription medication was not locked up.

The ED was interviewed on 6/29/26 and 6/30/26. She reported the Registered Nurse approved the order on the Medication Administration Record allowing staff to administer the Econazole Nitrate Cream daily without including the Mepilex dressing. Tenant #5's Power of Attorney (POA) contacted the Program while at the pharmacy on 6/19/26 and shared she would not privately pay for the ROHO cushion while it was pending insurance coverage. The Program needed to provide information to the pharmacy which they did. The POA was coordinating with the PCP for additional information. She was not aware of the need for Tenant #5 to be seen at the walk-in clinic or by the podiatrist and could not find documentation of these appointments having

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occurred. The ED confirmed there was no evidence on Tenant #5's task sheets of an increase in toileting checks. The task sheets did not include directives for staff to walk with Tenant #5, have her stand to increase blood flow or apply lotion to her legs. The ED would ensure Tenant #5's medication was stored in a locked drawer and applied appropriately. The ED confirmed Tenant #5 did not receive adequate care at the Program.

2) Record review on 6/24/26 of incident reports and Care History entries revealed the following for Tenant C3:
12/26/25: Staff heard Tenant C3 take a fall in her room. Staff responded quickly to the noise and found her on the floor. She said she hit her head and complained of left arm pain. Tenant C3 was assessed by the Health and Wellness Director (HWD) and hospice nurse. She reported generalized discomfort with ambulation. Planned interventions included additional toileting assistance and additional visuals for safety.

12/27/25: The HWD identified contributing factors to the 12/26/25 fall in a Care History note; these included poor balance/gait, medication side effects (dizziness), impaired judgement, vision changes, confusion, physical weakness and wandering, all of which were exacerbated by dementia's impact on brain function and safety awareness.

1/8/26 at 6:55 AM: Staff entered Tenant C3's room and found her on the floor next to her bed with a blanket around her feet. Tenant C3 said she was getting dressed and fell to the floor. She expressed discomfort in her left elbow. It was noted she was pleasantly confused per her

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baseline and remained independent with ambulation when using her wheeled walker.

1/13/26: A care history entry noted she was a little off baseline. During movement she seemed to forget what she was doing and would freeze mid-movement. Staff reported she needed assistance with taking her oral pills which was never an issue.

2/3/26: The Hospice social worker found Tenant C3 on the floor in her bathroom. She took a shower without staff assistance and slipped on the wet floor. The nurse assessed Tenant C3. She was cognitively intact and denied any pain. Interventions of fall follow-ups for three days would occur and her family would purchase Velcro shoes. Tenant C3 was educated to ask staff to help her with showering.

2/6/26: The HWD assessed Tenant C3 and noted her mood was pleasant, appetite low and she remained confused.

2/7/26 at 8:00 AM: The HWD assessed Tenant C3 and noted she was more tired in the mornings. Staffed confirmed Tenant C3 was up throughout the night. She had a decrease in appetite.

2/7/26 at 11:45 PM: Staff reported Tenant C3 slid from her recliner to the floor. She was assisted to her feet and into bed. She denied pain or discomfort. An intervention of an anti-slip pad for her chair was written on the report.

2/9/26 at 12:31 PM: Tenant C3 was found on the floor. She complained of falling and hitting her head on the floor. Tenant C3 was transferred to the hospital. An entry on a care history identified

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a contributing factor was Tenant C3's recent tiredness.

2/12/26: Tenant C3 was admitted to the hospital and diagnosed with an acute subdural hematoma. She received IV pain management and in-patient hospice care. As on 2/12/26 Tenant C3 was non-responsive. She died in the hospital on 2/22/26.

The Program was faxed a copy of Tenant C3's 1/13/26 Hospice Interdisciplinary Team Review on 1/21/26. It noted she was an 87-year-old woman with a primary terminal diagnosis of Alzheimer's Dementia who entered hospice on 11/24/25. She was oriented to self only and was unable to carry on a conversation. She used a walker for ambulation for gait instability. She needed assistance in all areas of activities of daily living with the exception of eating. Due to her impaired mobility, staff were to assist Tenant C3 to her room after meals to assure she got into her recliner or bed safely. Tenant C3 was at risk of falling so the HWD initiated an increase in rounding on 1/8/26 according to an entry on the plan. The Hospice Aide provided assistance to Tenant C3. She was directed to provide stand by assistance when assisting Tenant C3 with transfers and ambulation (as of 11/24/25).

Tenant C3 had a Resident Assessment (health, cognitive and functional evaluations) completed by the HWD on 12/21/25. The HWD's assessment varied greatly from that of the Hospice nurse, indicating Tenant C3 could communicate independently and was independent with dressing, grooming and dining. Tenant C3 also scored a 6 on the Global Deterioration Scale indicating a severe cognitive decline. She was independent with mobility with

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the use of a walker and did not need reminders to use an assistive device. The assessment noted Tenant C3 was a level 3 on the Morse Fall Screen indicating the need to implement high risk fall interventions, although none were listed on the Resident Assessment or 12/23/25 Care Plan.

A review of the Dec. 2025, Jan. 2026 and Feb. 2026 Task Administration Records revealed no increase in visual checks following Tenant C3's 12/26/25 fall, although there was an increase in toileting reminders. There was no task added for staff to provide standby assistance with transfers or walk with her to her room after meals.

During an interview with Tenant C3's hospice nurse on 6/29/26 at 12:10 PM she recalled the tenant started requiring standby assistance with transfers and verbal encouragement from staff in the weeks prior to her fall on 2/9/26 due to weakness. Her energy level could vary by the day. The hospice nurses from her agency would remind the Program workers they needed to provide additional assistance with mobility and standby assistance during transfers. The employees seemed receptive to these suggestions. The hospice nurse also told the HWD staff needed to check on Tenant C3 more frequently, provide standby assistance and walk with her. The HWD said she would communicate this to the staff and make sure they were doing this.

The Program had a Falls policy dated 6/13/24 which noted all tenants would be evaluated for fall risk and their service plans would be developed/updated accordingly. Should a tenant experience a fall, staff will provide immediate care and follow through with service planning. The community's fall reduction program evaluation

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A 122	Continued From page 11 included a fall risk evaluation which would be conducted by a licensed nurse or trained designee. Each tenant's identified fall risks would be addressed with recommended interventions which would be included in their service plan. Each tenant's service plan and fall risk evaluation would be reviewed and updated whenever a tenant had a first fall with no history of falls, two or more falls within 30 days, a fall with injury requiring medical intervention or treatment or a change in condition. For 48 hours following each shift the Director of Health and Wellness or designees on each shift will monitor the tenant and make a brief narrative charting entry. If a tenant is falling frequently, the Director of Health and Wellness may need to request 1:1 care if the tenant is not responding to interventions. When interviewed on 6/30/26 at 9:45am the Executive Director confirmed the HWD should have reassessed Tenant C3 following her falls to ensure she was receiving adequate care and treatment.	A 122		
A 152	481-67.5(2)e(3) Medications 481-67.5(231B,231C,231D) Medications. 67.5(2)?Each program shall follow its own written medication policy, including the following: e. When medications are administered traditionally by the program: (3) Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or PA.	A 152		

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A 152	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review Program staff failed to ensure medication was administered per the Nurse Practitioner's signed orders for 1 of 5 tenants reviewed (Tenant #5). Findings follow: Record review on 6/30/26 of an Order Summary Report dated 3/30/26 directed staff to apply Econazole Nitrate External Cream 1% to the sacrum topically every day shift and cover with Mepilex. A review of the April Medication Administration Record (MAR) revealed the directions for staff on application of Econazole Nitrate External Cream 1% were: Apply topically to sacrum every day shift. There was no mention of covering with Mepilex. The NP signed orders on 4/26/26 indicating staff could apply the Econazole Nitrate Cream without the Mepilex dressing. During a tour of Tenant #5's apartment on 6/25/26 at 2:45 PM a tube of Econazole Nitrate Cream 1% was seen on her sink top. Staff D reported the medication was stored on the sink top so staff could apply it when they assisted Tenant #5 with incontinence cares. Staff C was interviewed on 6/25/26 at 2:15 PM and explained she put the Econazole Nitrate Cream on Tenant #5's bottom when she took her to the bathroom. The cream was kept on top of the toilet but sometimes fell behind the toilet so employees might forget to put the medication on her wound. The Executive Director was interviewed on 6/30/26 at 9:45 AM. She confirmed the April	A 152		

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A 152	Continued From page 13 2026 MAR should have included directives for staff to cover Tenant #5's sacrum with Econazole Nitrate External Cream 1% and Mepilex dressing through 4/26/26. Staff should only apply the cream once daily and it should be stored in a locked cabinet.	A 152		
A 196	481-67.9(4)b Staffing 481-67.9(231B,231C,231D) 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 include the following: b. Within 30 days of beginning employment, all program staff will receive training by the program's nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure Nurse Delegation procedures were followed during the training of 6 of 6 employees reviewed (Staff B, Staff C, Staff D, Staff E, Staff F and Staff G). Findings follow: 1) a. Record review on 6/30/26 of a Nurse Delegation packet revealed the Registered Nurse (RN) and Staff C signed the forms on 6/12/26. An Employee list noted Staff C was hired as a Care Manager on 5/26/26. On 6/29/26 at 3:15 PM Staff C reported she received training from her co-workers such as the Care Managers and Med Techs. She was delegated by someone but did not know who.	A 196		

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She only saw the person who delegated her one time. Staff C did not believe she had seen a nurse when working at the Program other than the day she was delegated.

b. Staff D and the RN signed the Nurse Delegation packet on 6/12/26. An Employee list noted Staff D was hired on 5/26/26.

Staff D was interviewed on 6/25/26 at 2:45 PM and reported she had no experience working in health care. She received her training from other Care Managers and Med Techs. She did not meet the RN until they signed the delegation packet. The RN did not watch her complete tasks to ensure she knew how to complete them although they signed the delegation packet together.

c. Staff E and the RN signed the Nurse Delegation packet on 6/12/26. An Employee listed noted Staff E was hired on 5/1/26. Staff E was delegated more than 30 days after her hire date.

On 6/24/26 at 9:15 AM Staff E recalled receiving training from her co-workers. A nurse came to the building to delegate her but she did not know who it was. Staff E had not seen a nurse in the building since the time she was delegated. She did not have experience working with the elderly.

2) Record review on 6/30/26 of a Quick Confirm License Verification Report from Nursys provided by the Executive Director revealed Staff H had a Registered Nursing license in Arkansas which expired on 3/20/24. Staff H had a Multistate Practical Nursing license issued in Kansas on 7/24/15 which expired on 1/31/27. Included on the report was the following verbiage, "authority to

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practice as a licensed nurse in a remote state under the current license issued by the individual's home state provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted".

Emails from the Iowa Board of Nursing dated 6/30/26 and 7/2/26 indicated a nurse with a multistate license had 60 days after moving to get their Iowa Nursing License. Staff H did not obtain her Iowa nursing license. Staff H was hired at the Program on 1/6/25 as the Director of Health and Wellness and left employment on 3/9/26.

Staff H delegated Staff B on 2/21/26. Staff H identified herself as a Licensed Practical Nurse.

Staff H delegated Staff F on 1/27/26. Staff H identified herself as a Licensed Practical Nurse.

Staff H delegated Staff G on 1/27/26. Staff H identified herself as a Licensed Practical Nurse.

The Executive Director provide the delegation packets for Staff B, Staff F and Staff G on 7/8/26. She confirmed Staff H delegated these employees even though she was not a licensed nurse in Iowa. On 6/30/26 the Executive Director provided the Nursys information. She was not the Executive Director when the former Health and Wellness Director was hired but believed Staff H met the qualifications of a Licensed Practical Nurse in Iowa as she held a Multistate Practical Nursing license. She did not know Staff H was required to also obtain an Iowa Nursing license.

When interviewed on 6/30/26 at 9:45 AM the Executive Director confirmed employees provided training to new workers. She was not aware the

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A 196	Continued From page 16 Registered Nurse was required to train newly hired staff.	A 196		
A 232	481-69.22(3) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to fully evaluate 1 of 3 discharged tenants (Tenant C3) and 3 of 5 current tenants reviewed (Tenant #5, Tenant #2 and Tenant #1) by completing a health, functional and cognitive assessment when they experienced a change of condition. Findings follow: 1) Record review on 6/24/26 of incident reports and care history entries revealed the following for Tenant C3: - On 12/26/25, staff heard Tenant C3 take a fall in her room. Staff responded quickly to the noise and found her on the floor. She said she hit her head and complained of left arm pain. Tenant C3 was assessed by the Health and Wellness Director (HWD) and hospice nurse. She reported generalized discomfort with ambulation.	A 232		

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A 232	Continued From page 17 - On 1/8/26 at 6:55 AM staff entered Tenant C3's room and found her on the floor next to her bed with a blanket around her feet. Tenant C3 said she was getting dressed and fell to the floor. She expressed discomfort in her left elbow. - A care history entry dated 1/13/26 noted she was a little off baseline. During movement she seemed to forget what she was doing and would freeze mid-movement. Staff reported she needed assistance with taking her oral pills which was never an issue in the past. - The Hospice social worker found Tenant C3 on the floor in her bathroom 2/3/26. She took a shower without staff assistance and slipped on the wet floor. The nurse assessed Tenant C3. She was cognitively intact and denied any pain. - The HWD assessed Tenant C3 on 2/6/26 and noted her mood was pleasant, appetite low and she remained confused. - The HWD assessed Tenant C3 on 2/7/26 at 8:00 AM and noted she was more tired in the mornings. Staffed confirmed Tenant C3 was up throughout the night. She had a decrease in appetite. - On 2/7/26 at 11:45 PM staff reported Tenant C3 slid from her recliner to the floor. She was assisted to her feet and into bed. She denied pain or discomfort. - Tenant C3 was found on the floor on 2/9/26 at 12:31 PM. She complained of falling and hitting her head on the floor. Tenant C3 was transferred to the hospital. An entry on a care history identified a contributing factor was Tenant C3's recent tiredness.	A 232		

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- Tenant C3 was admitted to the hospital and diagnosed with an acute subdural hematoma. She received IV pain management and in-patient hospice care. As on 2/12/26 Tenant C3 was non-responsive. She died in the hospital on 2/22/26.

Tenant C3 had a Resident Assessment (health, cognitive and functional evaluations) completed by the HWD on 12/21/25. The assessment identified she could communicate independently. She was independent with dressing, grooming and dining. Tenant C3 scored a 6 on the Global Deterioration Scale indicating a severe cognitive decline. Staff provided 8 safety checks per shift. She was independent with mobility with the use of a walker and did not need reminders to use an assistive device.

During an interview with Tenant C3's hospice nurse on 6/29/26 at 12:10 PM she recalled the tenant started requiring standby assistance with transfers and verbal encouragement from staff in the few weeks prior to her fall on 2/9/26 due to her weakness. Her energy level could vary by the day. The hospice nurses from her agency would remind the Program workers they needed to provide additional assistance with mobility and standby assistance during transfers. The employees seemed receptive to these suggestions. The hospice nurse also told the Program nurse staff needed to check on Tenant C3 more frequently, provide standby assistance and walk with her. The Program nurse said she would communicate this to the staff and make sure they were doing this.

The Program's Falls policy, dated 6/13/24, noted all tenants would be evaluated for fall risk and

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their service plans would be developed/updated accordingly. Should a tenant experience a fall, staff would provide immediate care and follow through with service planning. The community's fall reduction program evaluation included a fall risk evaluation which would be conducted by a licensed nurse or trained designee. Each tenant's identified fall risks would be addressed with recommended interventions which would be included in their service plan. Each tenant's service plan and fall risk evaluation would be reviewed and updated whenever a tenant had a first fall with no history of falls, two or more falls within 30 days, a fall with injury requiring medical intervention or treatment or a change in condition. For 48 hours following each shift the Director of Health and Wellness or designees on each shift will monitor the tenant and make a brief narrative charting entry. If a tenant is falling frequently, the Director of Health and Wellness may need to request 1:1 care if the tenant is not responding to interventions.

The HWD failed to evaluate Tenant C3's needs when she had an increase in falls and change in her ability to complete her activities of daily living.

The Executive Director confirmed the Program failed to Tenant C3 when she had a change in her condition during an interview on 6/30/26 at 9:45 AM.

2) A review of Progress Notes on 6/29/26 from a Skilled Nurse (SN) at a Home Health Agency identified Tenant #5 began receiving wound care services for a Stage II Pressure ulcer on her coccyx on 4/27/26. A pressure ulcer to her coccyx was noted to be resolved during a visit on 5/7/26.

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The SN charted on 5/12/26 she received a call from staff at the Program notifying her Tenant #5 had a weeping, open area and as the Program staff could not provide wound care they needed the SN to see the patient that day. When the SN arrived Tenant #5 was sitting in a recliner with her legs minimally elevated. She had a small open area to the middle inner calf (Wound #2) which she'd bumped earlier resulting in the skin opening. Due to the severity of Tenant #5's leg swelling, the area would continue to weep until the edema decreased (pitting edema of +3 to the RLE and +2 to the LLE). The SN reported the wound to the tenant's Primary Care Provider (PCP) and she provided orders: apply foam dressing after applying skin prep to peri wound on the weeping areas of the left inner and posterior lower legs and change at least every 3-5 days or until saturated with drainage. The PCP prescribed TED hose to reduce Tenant #5's edema. The SN documented the Program employee told her she wasn't allowed to ask Tenant #5 if she was hurting and pain medication could only be administered if a tenant requested it. A previous nurse told the employee Lortab or Tramadol could be ordered by the PCP. The SN asked if Tylenol was easing Tenant #5's pain and the employee reported she hadn't administered this because it did not work. The SN was unsure of how the determination was made the Tylenol did not work as it did not appear anyone provided Tenant #5 with Tylenol.

The SN returned to the Program on 5/18/26 and Wound #2 was improving. The treatment remained the same: change the dressing at least every 3-5 days or until saturated with drainage. However on removal of her compression stockings it was observed the tenant had 2 new

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open areas at the same height as Wound #2. All wounds were weeping a significant amount of clear serous drainage. Tenant #5 did not want to sit in her recliner. The SN educated staff on hand washing the compression socks every night and hanging them to dry. She instructed them that if there was drainage leaking from the dressing they should remove the dressing. The SN provided this health information to Tenant #5's PCP who instructed the tenant to go to a walk-in clinic for medication to reduce the edema as the wounds would not heal and more could develop as long as the swelling remained in her legs (pitting edema of +3 in her right leg and +4 in her left leg).

When the SN met with Tenant #5 on 5/28/26 she continued to experience pitting edema in her legs (+2 in her right leg and +4 in her leg leg but all wounds to her legs were resolved. The SN talked with the Executive Director (ED) about the need for Tenant #5 to obtain a pressure relieving cushion for her wheelchair as this is where she spent most of her time. The ED explained sometimes the patient became upset and combative if she didn't want to get out of the wheelchair. The SN explained a cushion, preferably a ROHO cushion, was the best option to prevent pressure areas from continuously occurring. The SN told the ED she educated the staff last week to stand Tenant #5 up for 30 - 60 seconds to restore blood to her tissue about every hour. The ED then told the SN Tenant #5 had another red area on her right buttock but it wasn't open. The SN said she would observe and measure it next week as the treatment would not change from what was previously applied to her buttocks.

On 6/4/26 Tenant #5 met with the SN and had

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pitting edema of +4 to her left and right leg. The SN took her to the bathroom to observe the wound and found her incontinence brief was extremely wet. There was was a new pressure area over her Ischial tuberosity which staff were to cleanse with a wound cleanser and iodine two times weekly and cover with foam dressing until healed. It measured 3.7 cm x 2.4 cm x 0.1 cm. The SN discussed with staff on the unit the need to keep Tenant #5 as dry as possible and to place in a recliner or bed, not only the wheelchair. She reminded the ED and ARNP Tenant #5 would continue to have skin breakdown until she got a ROHO cushion for her wheelchair. The ED reported it was difficult to get in contact with Tenant #5's family but they were aware of the need to purchase the cushion. The wound was noted to be worsening when the SN visited on 6/8/26. She instructed staff to walk with Tenant #5 three times a day. On 6/17/26 the SN again documented the wound was worsening as there was 90% slough tissue and 10% granulation tissue. Staff reported they applied Econazole Cream twice daily and as needed to her buttocks (it was ordered once every morning). She would be discharged from skilled nursing the following week. At the time of Tenant #5's discharge from skilled nursing it was noted she was referred for a Stage II pressure ulcer which healed and then reappeared as she spent most of her time in a wheelchair. In order to prevent the condition from worsening she needed to wear compression stockings and get a cushion for her wheelchair.

Tenant #5 had a Resident Assessment dated 4/25/26 which noted she had Stage 2 pressure ulcer to her sacrum. The Registered Nurse did not reassess Tenant #5's condition when she developed edema and weeping areas or wounds to her lower extremities. The staff contacted the

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SN to address the tenant's needs rather than the Registered Nurse according to the skilled nursing notes. The Registered Nurse did not reassess Tenant #5 when a wound appeared on the Executive Director became aware of a new red area on her buttocks on 5/28/26, instead notifying the SN.

During an interview with the Executive Director on 6/30/26 at 9:45 AM she confirmed the Registered Nurse failed to evaluate Tenant #5's needs when she experienced a change of condition.

3) A review of Nursing Communication Forms for Tenant #2 revealed the following:
- On 5/30/26 staff was called to assist Tenant #2 who left the secured memory care area where she lived. She told staff she owned the building and then hit an employee in the face. Tenant #2 would not move from the exit doors for several minutes.

- Also on 5/30/26 Tenant #2 was standing by the door of the secured memory care area. When an employee came through the door, Tenant #2 exited the unit. When an employee tried to block the door Tenant #2 hit the employee.

- Tenant #2 entered other tenants' apartments throughout the day on 6/19/26. She removed their belongings and staff were unable to redirect her. Tenants were unhappy when staff asked them to lock the doors to their apartments.

During an interview with Staff A on 6/24/26 at 10:35 AM she reported Tenant #2 would attempt to exit the secured memory care unit throughout the day. She pressed on the double doors leading to the assisted living unit or the glass doors to the courtyard. Tenant #2 would wander

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into other tenant's apartments so they encouraged tenants to keep their doors shut. When Staff A redirected her away from doors or other tenant's apartments Tenant #2 would become upset. She displayed verbal and physical aggression daily and needed visual surveillance whenever she left her room.

Staff B was interviewed on 6/24/26 at 11:10 AM and explained Tenant #2 was confused and believed her family was in the building. She would wander around, knock on doors and try to leave through doors 3-5 times during her shift. Tenant #2 knew if she pushed a door hard enough she could get through. Staff B had been hit by Tenant #2 but she would raise her hand in an aggressive manner about 1-2 times a week.

When interviewed on 6/25/26 at 2:15 PM Staff C stated Tenant #2 would try and leave through the exit doors several times a day as well as enter other tenant's apartments. Tenant #2 had grabbed her by the arms in the past.

Tenant #2 had a Resident Assessment dated 5/18/26. It noted she had active behavioral issues such as non-compliance, refusal of care, agitation or anxiousness. There was no mention of verbal or physical aggression. Tenant #2's Care Plan noted she wandered in public areas but was not intrusive, which was not accurate as other tenants needed to lock their doors to keep her from entering their apartments. The Registered Nurse did not reassess her needs when Tenant #2 displayed exit-seeking and aggressive behaviors.

The Executive Director confirmed the Registered Nurse did not evaluate Tenant #2 when she displayed exit-seeking behavior or aggression

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A 232	Continued From page 25 during an interview on 6/30/26 at 9:45 AM. 4) Record review of a Resident Assessment dated 4/8/26 for Tenant #1 identified she was on a regular diet and independent with dining. She did not require any verbal prompting at mealtime. During an interview with Tenant #3 on 6/25/26 at 8:10 AM she reported witnessing Tenant #1 having a choking-like event a week earlier during the evening meal. There were no staff present in the dining room. Another tenant went to look for an employee who was found outside on a break. Tenant #1 was interviewed on 6/25/26 at 11:10 AM. She explained there were times when food got caught when she swallowed. This could be scary for some of the tenants. If she was actually choking, she would have given the other tenants the choking sign. She was upset there were no employees present during the event. Staff I was interviewed on 6/25/26 at 11:50 AM and reported Tenant #1 swallowed wrong and coughed really hard. Staff I noted Tenant #1 had a swallowing issue, although this was a worse episode than usual. The Program normally tried to keep employees in the dining room but on this date no one was present. As soon as a tenant came to get her she responded. The Registered Nurse did not evaluate Tenant #1's swallowing or dining needs following the event in the dining room. Tenant #1 and Staff I identified she could have swallowing issues at times but they were not noted on her Resident Assessment. The Executive Director confirmed Tenant #1 was	A 232		

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A 232	Continued From page 26 not evaluated by the Registered Nurse following her choking event. The Executive Director was not aware of the incident.	A 232		
A 268	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete nurses' notes by exception for 3 of 5 current tenants reviewed (Tenant 1, Tenant 2, Tenant 5). Findings follow: 1) Record review on 6/29/26 of Outside Agency Documentation forms, Provider Visit forms and an After Visit Summary for Tenant #5 revealed the following: - 5/12/26: Occupational therapist identified staff should continue to position her in the recliner and out of wheelchair every couple of hours. Keep encouraging activities to decrease behaviors. - 5/12/26: The Skilled Nurse noted Tenant #5 had an open weeping area to her left lower extremity. Her Primary Care Provider (PCP) was contacted and received an order for TED hose and stronger	A 268		

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pain medication.
- 5/18/26: The Skilled Nurse documented she was at the Program due to edema to Tenant #5's bilateral lower extremities and weeping open areas. She asked staff to watch for bunching areas on the TED hose around the top of the foot and bottom of the leg to prevent pressure. Skilled nursing visits would increase as the wounds increase from 1 to 3. Foam dressings were applied. If drainage was coming out around the dressing it should be removed.
- On 5/20/26, an After Visit Summary note from the Emergency Room noted Tenant #5 was seen in the Emergency Room due to lip swelling. She was to discontinue the medication Tramadol and start taking Claritin and Prednisone for 5 days. She should use cool compresses for 15 minutes several times daily and have close primary care follow-up.
- On 5/21/26 the Occupational Therapist directed staff to have Tenant #5 get out of her wheelchair and change positions every couple of hours. She should sit in her chair with the air cushion throughout the day.
- The Skilled Nurse visited Tenant #5 on 6/8/26 and provided a number of directives: Wound care provided and covered with a transparent dressing which was waterproof. Staff should leave it on unless it was soiled. Tenant #5 needed to walk three times a day, preferably with shoes or slippers on but per the Physical Therapist it was not worth it if she was refusing. Please walk from her apartment to the dining area or dining room to the toilet. Her urine smells strong. Encourage fluids. The PCP's office was contacted to write a prescription for a wheelchair cushion.
- Tenant #5 needed to be seen by a podiatrist for a foot assessment according to the SN who saw her on 6/17/26.
- When discharged from Physical Therapy,

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Occupational Therapy and Skilled Nursing on 6/22/26, the SN noted she was saturated with urine and itching in the perineal area. She needed to be cleaned well in all areas that came in contact with urine. She was itching under her breasts and could use corn starch, baby powder or Nystatin to treat this. The wound on her buttocks measured 3.3 x 1.5. She was not wearing TED hose. Staff should moisturize her lower extremities but not between her toes. All staff should assist her with walking three times daily and provide toileting assistance every two hours. She should stand up for once minute every hour if she was not walking.

There were no nurse's notes in the record for Tenant #5 after 4/30/26.

2) Record review on 6/30/26 of Nursing Communication Forms for Tenant #2 revealed the following:
- On 5/30/26 staff was called to assist with Tenant #2 who left the secured memory care area where she lived. She told staff she owned the building and then hit an employee in the face. Tenant #2 would not move from the exit doors for several minutes.

- On 5/30/26 Tenant #2 was standing by the door of the secured memory care area. When an employee came through the door, Tenant #2 exited the unit. When an employee tried to block the door Tenant #2 hit the employee.

- Tenant #2 entered other tenants' apartments throughout the day on 6/19/26. She removed their belongings and staff were unable to redirect her. Tenants were unhappy when staff asked them to lock the doors to their apartments.

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A 268	Continued From page 29 During an interview with Staff A on 6/24/26 at 10:35 AM she reported Tenant #2 would attempt to exit the secured memory care unit throughout the day. She pressed on the double doors leading to the assisted living unit or the glass doors to the courtyard. Tenant #2 would wander into other tenant's apartments so they encouraged tenants to keep their doors shut. When Staff A redirected her away from doors or other tenant's apartments Tenant #2 would become upset. She displayed verbal and physical aggression daily and needed visual surveillance whenever she left her room. Staff B was interviewed on 6/24/26 at 11:10 AM and explained Tenant #2 was confused and believed her family was in the building. She would wander around, knock on doors and try to leave through doors 3-5 times during her shift. Tenant #2 knew if she pushed a door hard enough she could get through. Staff B had been hit by Tenant #2 but she would raise her hand in an aggressive manner about 1-2 times a week. When interviewed on 6/25/26 at 2:15 PM Staff C stated Tenant #2 would try and leave through the exit doors several times a day as well as enter other tenant's apartments. Tenant #2 had grabbed her by the arms in the past. There were no nurse's notes in the record documenting any of these events for Tenant #2. 3) During an interview with Tenant #3 on 6/25/26 at 8:10 AM she reported witnessing Tenant #1 having a choking-like event a week earlier during the evening meal. There were no staff present in the dining room. Another tenant went to look for an employee who was found outside on a break.	A 268		

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A 268	Continued From page 30 Tenant #1 was interviewed on 6/25/26 at 11:10 AM. She explained there were times when food got caught when she swallowed. This could be scary for some of the tenants. If she was actually choking, she would have given the other tenants the choking sign. She was upset there were no employees present during the event. Staff I was interviewed on 6/25/26 at 11:50 AM and reported Tenant #1 swallowed wrong and coughed really hard. Staff I noted Tenant #1 had a swallowing issue, although this was a worse episode than usual. The Program normally tried to keep employees in the dining room but on this date no one was present. As soon as a tenant came to get her she responded. There were no entries in the nurse's notes describing this event for Tenant #3. On 6/30/26 at 9:45 AM the Executive Director confirmed the Program failed to document all required entries in the nurse's notes.	A 268		
A 274	481-69.25(1)o Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports need not be included in the tenant's medical record);	A 274		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review Program staff failed to complete incident report forms for each incident involving 2 of 5 tenants reviewed (Tenant #1 and Tenant #2). Findings follow:

1) Record review on 6/30/26 of Nursing Communication Forms for Tenant #2 revealed the following:
- On 5/30/26 staff was called to assist with Tenant #2 who left the secured memory care area where she lived. She told staff she owned the building and then hit an employee in the face. Tenant #2 would not move from the exit doors for several minutes.

- On 5/30/26 Tenant #2 was standing by the door of the secured memory care area. When an employee came through the door, Tenant #2 exited the unit. When an employee tried to block the door Tenant #2 hit the employee.

2) Record review of a Care History report (progress notes) for Tenant #1 showed no entries after 4/30/26. Tenant #1 had incident reports dated 4/4/26 and 5/17/26 for unwittness falls.

During an interview with Tenant #3 on 6/25/26 at 8:10 AM she reported witnessing Tenant #1 having a choking-like event a week earlier during the evening meal. There were no staff present in the dining room. Another tenant went to look for an employee who was found outside on a break.

Tenant #1 was interviewed on 6/25/26 at 11:10 AM. She explained there are times when food gets caught when she was swallows. This can be scary for some of the tenants. If she was actually choking, she would have given the other tenants

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A 274	Continued From page 32 the choking sign. She was upset there were no employees present. Staff I was interviewed on 6/25/26 at 11:50 AM and reported Tenant #1 swallowed wrong and coughed really hard. While Tenant #1 has a swallowing issue, this was a worse episode than usual. The Program normally tried to keep employees in the dining room but on this date no one was present. As soon as a tenant came to get her she responded. Staff I did not fill out an incident report but looking back on it she thinks she probably should have done so. There were no incident reports for the situations involving Tenant #2 or Tenant #1. The Program had a policy on Incident Reports dated 6/13/24 which noted an Internal Occurrence Report would be completed by staff for all unusual occurrences and incidents. On 6/30/26 at 11:30 AM the Executive Director confirmed the Program failed to ensure Internal Occurrence Report forms were written for all incidents. The Executive Director reported she reviewed the Nursing Communication Forms written by staff.	A 274		
A 282	481-69.26(3) Service Plans 481-69.26(231C) 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. The service plan shall be signed by all parties, including the tenant or	A 282		

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A 282	Continued From page 33 tenant's legal representative. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update the service plans of 1 of 3 discharged tenants (Tenant C3) and 2 of 5 current tenants reviewed (Tenant #5 and Tenant #2). Findings follow: 1) Record review on 6/24/26 of incident reports and Care History entries revealed the following for Tenant C3: - On 12/26/25, staff heard Tenant C3 take a fall in her room. Staff responded quickly to the noise and found her on the floor. She said she hit her head and complained of left arm pain. Planned interventions included additional toileting assistance and additional visuals for safety. The Health and Wellness Director (HWD) identified contributing factors to the 12/26/25 fall in a Care History note dated 12/27/25; these included poor balance/gait, medication side effects (dizziness), impaired judgement, vision changes, confusion, physical weakness and wandering, all of which were exacerbated by dementia's impact on brain function and safety awareness. - On 1/8/26 at 6:55 AM staff entered Tenant C3's room and found her on the floor next to her bed with a blanket around her feet. Tenant C3 said she was getting dressed and fell to the floor. She expressed discomfort in her left elbow. It was noted she was pleasantly confused per her baseline and remained independent with ambulation when using her wheeled walker. - A Care History entry dated 1/13/26 noted she was a little off baseline. During movement she	A 282		

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seemed to forget what she was doing and would freeze mid-movement. Staff reported she needed assistance with taking her oral pills which was never an issue in the past.

- The Hospice social worker found Tenant C3 on the floor in her bathroom 2/3/26. She took a shower without staff assistance and slipped on the wet floor. No injuries were noted.

- The HWD assessed Tenant C3 on 2/7/26 at 8:00 AM and noted she was more tired in the mornings. Staffed confirmed Tenant C3 was up throughout the night. She had a decrease in appetite.

- On 2/7/26 at 11:45 PM staff reported Tenant C3 slid from her recliner to the floor. She was assisted to her feet and into bed. She denied pain or discomfort. An intervention of an anti-slip pad for her chair was written on the report.

- Tenant C3 was found on the floor on 2/9/26 at 12:31 PM. She complained of falling and then hitting her head on the floor. Tenant C3 was transferred to the hospital. An entry on a care history identified a contributing factor was Tenant C3's recent tiredness.

- Care History entries noted Tenant C3 was admitted with a diagnosis of acute subdural hematoma. She required IV pain management and was under the care of hospice during her stay in the hospital. Tenant C3 died on 2/22/26.

The Program was faxed a copy of Tenant C3's 1/13/26 Hospice Interdisciplinary Team Review on 1/21/26. It noted she was an 87-year-old woman with a primary terminal diagnosis of Alzheimer's Dementia who entered hospice on 11/24/25. She

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was oriented to self only and was unable to carry on a conversation. She used a walker for ambulation for gait instability. She needed assistance in all areas of activities of daily living with the exception of eating. Due to her impaired mobility, staff were to assist Tenant C3 to her room after meals to assure she got into her recliner or bed safely. Tenant C3 was at risk of falling so the Program nurse initiated an increase in rounding on 1/8/26 according to an entry on the plan. The Hospice Aide provided assistance to Tenant C3. She was directed to provide stand by assistance when assisting Tenant C3 with transfers and ambulation (as of 11/24/25).

Tenant C3 had a service plan dated 12/23/25. The service plan noted she could communicate independently. She was independent with dressing, grooming and dining. Staff provided 8 safety checks per shift. She received toileting assistance. She was independent with mobility with the use of a walker. The plan noted Tenant C3 was a level 3 on the Morse Fall Screen indicating the need to implement high risk fall interventions. There were no needs or preferences listed for Tenant C3 in the provided section.

During an interview with Tenant C3's hospice nurse on 6/29/26 at 12:10 PM she recalled the tenant started requiring standby assistance with transfers and verbal encouragement from staff in the few weeks prior to her fall on 2/9/26 due to her weakness. Her energy level could vary by the day. The hospice nurses from her agency would remind the Program workers they needed to provide additional assistance with mobility and standby assistance during transfers. The employees seemed receptive to these suggestions. The hospice nurse also told the

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A 282	Continued From page 36 HWD staff needed to check on Tenant C3 more frequently, provide standby assistance and walk with her. The HWD said she would communicate this to the staff and make sure they were doing this. The Program's Falls policy, dated 6/13/24, noted all tenants would be evaluated for fall risk and their service plans would be developed/updated accordingly. Should a tenant experience a fall, staff will provide immediate care and follow through with service planning. The community's fall reduction program evaluation included a fall risk evaluation which would be conducted by a licensed nurse or trained designee. Each tenant's identified fall risks would be addressed with recommended interventions which would be included in their service plan. Each tenant's service plan and fall risk evaluation would be reviewed and updated whenever a tenant had a first fall with no history of falls, two or more falls within 30 days, a fall with injury requiring medical intervention or treatment or a change in condition. For 48 hours following each shift the Director of Health and Wellness or designees on each shift will monitor the tenant and make a brief narrative charting entry. If a tenant is falling frequently, the Director of Health and Wellness may need to request 1:1 care if the tenant is not responding to interventions. The Program failed to update the service plan for Tenant C3 according to the Falls policy when she had 2 falls within 30 days (1/8/26 and 2/3/26). Tenant C3 also experienced a change of condition related to her ability to communicate and complete her activities of daily living. The HWD documented Tenant C3 was more confused, tired and had changes in her gait.	A 282		

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A 282	Continued From page 37 The Executive Director confirmed the Program failed to update Tenant C3's service plan during an interview on 6/30/26 at 9:45 AM. 2) A. Review on 6/29/26 of a physical exam for Tenant #5 dated 4/3/26 revealed she was a 77-year-old female who presented to the appointment in a wheelchair. She had a medical history of Type II diabetes, osteoarthritis, pressure ulcer, encephalopathy, severe rhabdomyolysis, and hyperkalemia. A Tenant list provided by the Executive Director noted Tenant #5 moved to the program on 3/27/26. A review of Progress Notes from a Skilled Nurse (SN) at a Home Health Agency identified Tenant #5 began receiving services at their agency on 4/27/26. A pressure ulcer to her coccyx was noted to be resolved during a visit on 5/7/26. The SN charted on 5/12/26 she received a call from staff at the Program notifying her Tenant #5 had a weeping, open area and because they could not provide wound care they needed the SN to see the patient that day. Upon the arrival of the SN Tenant #5 was sitting in a recliner with her legs minimally elevated. She had a small open area to the middle inner calf which was bumped resulting in the skin opening. Due to Tenant #5's leg swelling, the area would continue to weep until the edema decreased. The SN reported the wound to the tenant's Primary Care Provider (PCP) and she provided wound care orders and TED hose to reduce Tenant #5's edema. The SN returned to the Program on 5/18/26 and Wound #2 was improving. However on removal of her compression stockings it was observed she had 2 new open areas at the same height as Wound #2. All wounds were weeping a significant amount of clear serous drainage.	A 282		

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(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
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Tenant #5 did not want to sit in her recliner. The SN educated staff on hand washing the compression socks every night and hanging them to dry.

When the SN met with Tenant #5 on 5/28/26 she continued to experience pitting edema in her legs but all wounds to her legs were resolved. The SN talked with the Executive Director (ED) about the need for Tenant #5 to obtain a pressure relieving cushion for her wheelchair as this was where she spent most of her time. The ED explained sometimes the patient became upset and combative if she didn't want to get out of the wheelchair. The SN explained a cushion, preferably a ROHO cushion, was the best option to prevent pressure areas from continuously occurring. The SN told the ED she educated the staff last week to stand Tenant #5 up for 30 - 60 seconds to restore blood to her tissue about every hour. The ED then told the SN Tenant #5 had another red area on her right buttock but it wasn't open.

On 6/4/26 Tenant #5 met with the SN and had pitting edema. The SN took her to the bathroom to observe the wound and found her incontinence brief was extremely wet. There was was a new pressure area over her Ischial tuberosity. The SN discussed with staff on the unit the need to keep Tenant #5 as dry as possible and to place in seating other than her wheelchair such as bed or a recliner. She reminded the ED and ARNP Tenant #5 would continue to have skin breakdown until she got a ROHO cushion for her wheelchair. The ED reported it was difficult to get in contact with Tenant #5's family but they were aware of the need to purchase the cushion. The wound was noted to be worsening when the SN visited on 6/8/26. She instructed staff to walk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0170	A. BUILDING: _____ B. WING _____	C 07/08/2026

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ADDINGTON PLACE OF FAIRFIELD	3000 WEST MADISON AVENUE FAIRFIELD, IA 52556

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with Tenant #5 three times a day.

On 6/17/26 the SN again documented the wound was worsening as there was 90% slough tissue and 10& granulation tissue. Staff reported they applied Econazole Cream twice daily and as needed to her buttocks (it was ordered once every morning). She would be discharged from skilled nursing the following week. At the time of Tenant #5's discharge from skilled nursing on 6/22/26 it was noted she was referred for a Stage II pressure ulcer which healed and then reappeared as she spent most of her time in a wheelchair. In order to prevent the condition from worsening she needed to wear compression stockings and get a cushion for her wheelchair.

Tenant #5 had a service plan dated 5/13/26 which noted she had Stage 2 pressure ulcer to her sacrum. Her wounds were managed by the Skilled Nurse. There was no mention of the initial wound healing or later re-appearing on 5/28/26. The service plan was not updated when Tenant #5 developed edema or weeping areas to her lower extremities. Her service plan noted she did not exhibit any behavioral issues although the ED told the SN she could become combative. The service plan was not updated to reflect the need for staff to walk with Tenant #5, have her stand once an hour to increase the blood flow to her tissue or ensure her brief was dry.

During an interview with the Executive Director on 6/30/26 at 9:45 AM she confirmed the service plan was not updated to address the changes to Tenant #5's skin.

3) A. Review of Nursing Communication Forms for Tenant #2 revealed the following:
- On 5/30/26 staff was called to assist with Tenant

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	S0170	A. BUILDING: _____ B. WING _____	C 07/08/2026

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#2 who left the secured memory care area where she lived. She told staff she owned the building and then hit an employee in the face. Tenant #2 would not move from the exit doors for several minutes.

- On 5/30/26 Tenant #2 was standing by the door of the secured memory care area. When an employee came through the door, Tenant #2 exited the unit. When an employee tried to block the door Tenant #2 hit the employee.

- Tenant #2 entered other tenants' apartments throughout the day on 6/19/26. She removed their belongings and staff were unable to redirect her. Tenants were unhappy when staff asked them to lock the doors to their apartments.

During an interview with Staff A on 6/24/26 at 10:35 AM she reported Tenant #2 would attempt to exit the secured memory care unit throughout the day. She pressed on the double doors leading to the assisted living unit or the glass doors to the courtyard. Tenant #2 would wander into other tenant's rooms so they encouraged other tenants to keep their doors shut. When Staff A redirected her away from doors or other tenant's apartments Tenant #2 would become upset. She displayed verbal and physical aggression daily and needed visual surveillance whenever she left her room.

Staff B was interviewed on 6/24/26 at 11:10 AM and explained Tenant #2 was confused and believed her family was in the building. She would wander around, knock on doors and try to leave through exit doors 3-5 times during her shift. Tenant #2 knew if she pushed a door hard enough she could get through. Staff B had been hit by Tenant #2 but she would also raise her

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hand in aggression about 1-2 times a week.

When interviewed on 6/25/26 at 2:15 PM Staff C stated Tenant #2 would try and leave through the exit doors several times a day as well as enter other tenant's apartments. Tenant #2 grabbed her by the arms in the past.

Tenant #2 had a Care Plan dated 5/18/26. It noted she had active behavioral issues such as non-compliance, refusal of care, agitation or anxiousness. There was no mention of verbal or physical aggression. Tenant #2's Care Plan noted she wandered in public areas but was not intrusive, which was not accurate as other tenants needed to lock their doors to keep her from entering their apartments. There was no mention of Tenant #2 actively attempting to leave the memory care unit.

B. The Executive Director provided an Active Resident List on 6/24/26. Tenant #2's admission date was listed as 5/29/26. The Program had not developed a 30-day Care Plan for Tenant #2 as of the exit meeting on 6/30/26, more than 30 days after her admission.

The Executive Director confirmed Tenant #2's Care Plan did not address her exit-seeking behaviors or physical aggression during an interview on 6/30/26 at 9:45 AM. She also confirmed the Program did not update Tenant #2's Care Plan within 30 days of her admission.

Plan of Correction
Addington Place of Fairfield
Provider Number S0170 | Survey Completed July 8, 2026

Statement received: September 2, 2026

Plan submission deadline: September 17, 2026

Responsible leadership:

Executive Director, The Director of Health and Wellness and/or designee

Purpose: This Plan of Correction addresses each regulatory insufficiency identified during the investigation of complaint number 131442-C and 131535-C. The Program will correct the individual findings, implement system-level controls to prevent recurrence, and monitor continued compliance.

A 122 Tenant Rights

1. Correction: The Director of Health and Wellness and/or designee and Executive Director will review the complete records of the affected current tenant, reconcile current provider and outside-agency directions, update interventions if indicated, and communicate the revised plan to direct-care staff. The Director of Health and Wellness and/or designee will gather records, verify that assigned tasks are entered, and confirm staff receipt of the revised instructions. Because the discharged tenant is no longer served by the Program, no direct correction can be made for the tenant; the Program will use the finding to correct its system for recognizing and responding to changes in condition.

2. Measures to prevent recurrence:

- The Director of Health and Wellness and/or designee will complete a clinical review of every current tenant with a wound, recurrent falls, significant behavioral change, or outside skilled services to verify current orders, assessments, interventions and follow-up.
- By September 30, 2026, all caregivers and medication technicians will receive an in-service on completing observation notes and using after-shift reports so changes in condition are communicated to the Director of Health and Wellness and/or designee and next shift. Attendance and completion will be documented, and absent employees will complete make-up education before September 30th, 2026.
- Staff will promptly report new wounds, drainage, pain, falls, mobility decline, cognition changes, intake concerns, exit-seeking, aggression, or other significant changes to The Director of Health and Wellness and/or designee. The Director of Health and Wellness and/or designee will evaluate the tenant, notify the provider and responsible party as indicated, and determine required revisions to the service plan and staff instructions.
- The Director of Health and Wellness and/or designee will collect outside-agency recommendations and provider orders and complete the clinical review before implementation; The Director of Health and Wellness and/or designee will then verify incorporation into the tenant record, task system and service plan as applicable.

3. Monitoring for ongoing compliance: The Executive Director and Director of Health and Wellness and/or designee will audit all current tenants with a wound, recurrent falls, significant behavioral change, or outside skilled services by September 30, 2026. The Director of Health and Wellness and/or designee will review clinical change-of-condition documentation weekly for four weeks and monthly for three months. The Executive Director will review audit results, ensure omissions are corrected promptly, and retain completed audit records. Compliance will be sustained at 100 percent.

Correction date: The insufficiency will be corrected by September 30, 2026.

A 152 Medications

1. **Correction:** The Director of Health and Wellness and/or designee will obtain or verify complete signed orders and reconcile each order with the medication administration record, treatment record and service plan. The Director of Health and Wellness and/or designee will clarify discrepancies with the prescriber before staff continue administration under the revised direction.
2. **Measures to prevent recurrence:**
3. The Director of Health and Wellness and/or designee will prepare all active medication and treatment records for review and will clinically audit the orders against the electronic or paper administration records.
4. Only the Director of Health and Wellness and/or designee will enter or transcribe medication and treatment directions according to Program policy. The Director of Health and Wellness and/or will verify the transcription against the signed order before use.
5. Medication technicians will be re-educated by October 1, 2026 to administer and document medications and treatments exactly as ordered and to stop and notify the Director of Heath and Wellness and/or designee when an order is incomplete, inconsistent, or differs from the administration record.
6. The Director of Health and Wellness and/or designee will reconcile new and modified provider orders within one business day and again during the routine quarterly medication review.

3. Monitoring for ongoing compliance: The Director of Health and Wellness and/or designee will complete the initial 100 percent order-to-record reconciliation by October 1, 2026. The Director of Health and Wellness and/or designee will audit 3 medication or treatment orders weekly for four weeks and monthly for three months. Any variance will be corrected before the next administration when possible and findings will be reported to the Executive Director. The compliance goal is 100 percent.

4. Correction date: The insufficiency will be corrected by October 1, 2026.

A 196 Staffing

1. Correction: The Executive Director and the Director of Health and Wellness and/or designee will review every caregiver and medication technician file and maintain a list of missing requirements. The Director of Health and Wellness and/or designee will review clinical training records and complete required competency validation and delegation within 30 days of hire.

2. Measures to prevent recurrence

- The Executive Director will verify the active Iowa license of each delegating nurse before the nurse provides training, competency validation, or delegation.
- The Director of Health and Wellness and/or designee will validate competency for each assigned delegated task, and document tenant-specific delegation within 30 days of hire and before independent performance.

- The Director of Health and Wellness and/or designee will maintain a delegation tracker for new hires for 3 months that includes hire date, training dates, competency validation, delegating nurse, and delegated tasks. The Executive Director will review the tracker before staff is scheduled independently.
- Caregivers and medication technicians will be educated that they may perform only tasks for which they are trained, competent and delegated, and must report any gap before accepting an assignment.

3. Monitoring for ongoing compliance: The Executive Director and Director of Health and Wellness and/or designee will complete a 100 percent personnel-file and delegation-record audit by October 1, 2026. The Director of Health and Wellness and/or designee will validate the clinical training, competency and delegation entries. For 6 weeks, the Executive Director will compare new hires and current assignments with completed requirements. Any gap will result in immediate removal from the affected task until corrected. The compliance goal is 100 percent.

4. Correction date: The insufficiency will be corrected by October 1, 2026.

A 232 Evaluation of Tenant

1. **Correction:** The Director of Health and Wellness and/or designee will reassess tenants with significant changes through observation notes, incident reports and after-shift. The Director of Health and Wellness and/or designee will complete or appropriately arrange required evaluations for current tenants identified through the audit. Evaluations will address the tenant's current condition, risks, service needs, provider directions, outside-agency recommendations and need for service-plan revision. Findings will be communicated to the tenant or responsible party and direct-care staff as applicable.
2. **Measures to prevent recurrence:**
    - The Executive Director and Director of Health and Wellness and/or designee will review all tenant charts for document completeness.
    - By September 30, 2026, caregivers and medication technicians will receive an in-service on documenting observation notes and using after-shift reports to communicate changes requiring Director of Health and Wellness and/or designee review. Attendance and completion will be documented, and absent employees will complete make-up education before September 30, 2026.
    - The Director of Health and Wellness and/or designee will review observation notes, incident reports, after-shift reports and outside-provider documents each for completion and escalation for 6 weeks. The Director of Health and Wellness and/or designee will review clinical concerns and complete or arrange a reassessment whenever required by a significant change in condition or service need.
3. **Monitoring for ongoing compliance:** The Executive Director and The Director of Health and Wellness and/or designee will complete the initial document audit by September 30, 2026. The Director of Health and Wellness and/or designee will audit due-date completion weekly for four weeks and monthly for three months. Missed or incomplete evaluations will be completed promptly and addressed through retraining or performance management. The compliance goal is 100 percent.
4. **Correction date:** The insufficiency will be corrected by September 30, 2026.

A 268 Tenant Documents

1. **Correction:** The Executive Director and The Director of Health and Wellness and/or designee will review all current tenant charts to identify gaps in current information. The Director of Health and Wellness and/or designee will enter a current note for each tenant requiring clinical follow-up, documenting present status, assessment, notifications, orders, interventions and service-plan changes.
2. **Measures to prevent recurrence:**
    - By September 30, 2026, caregivers and medication technicians will receive an in-service requiring observation notes and after-shift reports for changes, unusual events and follow-up needs. Attendance and completion will be documented, and absent employees will complete make-up education before September 30th, 2026.
    - The Director of Health and Wellness and/or designee will review observation notes and after-shift reports each week for 4 weeks for completion. The Director of Health and Wellness and/or designee will document nursing assessment, provider or family notification, directions received, interventions and resolution.
    - The Executive Director will ensure the Program has identified coverage responsible for timely clinical review and nursing documentation when the primary Director of Health and Wellness and/or designee is unavailable.
3. **Monitoring ongoing compliance:** The Executive Director and The Director of Health and Wellness and/or designee will complete the initial chart-completeness review by October 1, 2026, and The Director of Health and Wellness and/or designee will complete the required clinical follow-through. The Director of Health and Wellness and/or designee will audit 2 tenant charts weekly for 6 weeks for required documents and the Executive Director will review results. Deficiencies will be corrected promptly, and trends will be addressed with additional education or corrective action. The compliance goal is 100 percent.
4. **Correction date:** The insufficiency will be corrected by October 1, 2026.

A 274 Tenant Documents

1. **Correction:** The Director of Health and Wellness and/or designee and Executive Director will review observation notes, after-shift reports and other available current records to identify recent events requiring an incident report and ensure the event, immediate response, notifications, investigation and corrective follow-up are documented.
2. **Measures to prevent recurrence:**
    - All caregivers and medication technicians will be re-educated on events requiring an incident report, including falls, injuries, medication variances, elopement or exit-seeking, aggression, missing-person or supervision concerns, missed care or meals, and other unusual occurrences by October 1, 2026.
    - The employee identifying the event will initiate the incident report before leaving the shift unless emergency care takes priority.
    - The Director of Health and Wellness and/or designee will complete the clinical assessment and determine needed service-plan revisions. The Executive Director will review each incident for investigation, reporting obligations, root cause and system correction.
    - After-shift reports will include confirmation that each unusual event has a corresponding incident report or an explanation of why one was not required.
3. **Monitoring for ongoing compliance:** The Director of Health and Wellness and/or designee will verify clinical assessment and service-plan follow-through when indicated. The Executive Director will audit all incidents weekly for four weeks and monthly for three months. Missing reports or follow-up will be completed promptly and addressed through education or performance management. The compliance goal is 100 percent.

4. Correction date: The insufficiency will be corrected by October 1, 2026.

A 282 Service Plans

1. **Correction:** The Director of Health and Wellness and/or designee will gather current evaluations, provider orders, nursing notes, incidents, observation notes and outside-agency recommendations for each tenant identified in the findings or chart audit. The Director of Health and Wellness and/or designee and Executive Director will review and update the service plans, with the Director of Health and Wellness and/or designee determining clinical and health-related interventions. The Director of Health and Wellness and/or designee will verify that approved tasks are entered and revised instructions are communicated to staff and the tenant or responsible party as required by October 1, 2026.
2. **Measures to prevent recurrence:** The Executive Director and The Director of Health and Wellness and/or designee will complete a document comparison to confirm that each current service plan matches the most recent evaluation, provider orders, nursing notes, incidents, observation notes and outside-agency recommendations. Clinical discrepancies will be referred to The Director of Health and Wellness and/or designee.

- The Director of Health and Wellness and/or designee and Executive Director will ensure a service plan is revised promptly whenever an evaluation identifies a change in condition or services.
- Caregivers and medication technicians will document observations and use after-shift reports so the Director of Health and Wellness and/or designee receives the information needed to determine whether reassessment and service-plan revision are required.
- After each service-plan update, The Director of Health and Wellness and/or designee will communicate interventions to all assigned staff and document that communication.

3. Monitoring for ongoing compliance: The Executive Director and The Director of Health and Wellness and/or designee will complete the 100 percent current-tenant document comparison, and The Director of Health and Wellness and/or designee will validate clinical content and required updates, by October 1, 2026. The Director of Health and Wellness and/or designee will track all new admissions and changed service plans weekly for four weeks and monthly for three months. The Executive Director will review timeliness and The Director of Health and Wellness and/or designee will validate clinical sufficiency. Overdue or inaccurate plans will be corrected promptly and responsible staff will receive retraining or corrective action. The compliance goal is 100 percent.

4. Correction date: The insufficiency will be corrected by October 1, 2026