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
	S0355	A. BUILDING: _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT GREEN MEADOWS	6750 CORPORATE DRIVE JOHNSTON, IA 50131

(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	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 30 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 31 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 6 Total Population of Program at time of on-site: 8 TOTAL census of Assisted Living Program: 39 The following regulatory insufficiencies were cited during the initial certification visit conducted to determine compliance with certification for an Assisted Living Program for People with Dementia (ALP/D):	A 000		
A 086	481-69.26(3)a 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. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.	A 086		

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

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
	S0355	A. BUILDING: _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT GREEN MEADOWS	6750 CORPORATE DRIVE JOHNSTON, IA 50131

(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 086	Continued From page 1	A 086		

This REQUIREMENT is not met as evidenced by:
Based on a review of the clinical records for four tenants, service plans were not signed and dated when updated with change for three tenants.

1. Tenant #1, a 92 year-old, was admitted on 3-26-16 and had diagnoses of: dementia, depressive disorder, hypertension, and history of falls. Tenant #1 was staged at three on the global deterioration scale (GDS) which indicated mild cognitive decline. Tenant #1 resided in the secured dementia unit.

A fax dated 6-10-16 documented Tenant #1 fell on 6-6-16 and was sent to the emergency room after hitting his/her head.

An undated service plan, updated of 6-8-16, indicated signatures were required. The service plan was not signed by either the nurse and the tenant or legal representative.

2. Tenant #2, a 91 year-old, was admitted on 2-1-16 and had diagnoses of: chronic kidney disease, hypertension, atrial fibrillation, congestive heart failure, osteoarthritis and gastroesophageal reflux disease.

A service plan, dated 7-25-16, was identified as being completed with a change of condition. The service plan was not signed by the tenant.

3. Tenant #4, a 77 year-old, was admitted on 4-30-16 and had diagnoses of: dementia, depressive disorder, and hypertension. Tenant

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
	S0355	A. BUILDING: _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT GREEN MEADOWS	6750 CORPORATE DRIVE JOHNSTON, IA 50131

(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 086	Continued From page 2 #4 was staged at six on the GDS which indicated severe cognitive decline. Tenant #4 resided in the secured dementia unit. A 90-day nurse review was completed on 7-26-16 and the service plan was updated as a result. The 90-day review documented changes in the activities of daily living related to toileting. The undated service plan, updated 7-25 and 7-26-16 indicated signatures were required. The service plan was not signed by either the nurse and the tenant or legal representative. The Program was unable to provide signature pages for the service plans when asked.	A 086		
A 093	481-69.26(4)e Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: e. Preferences, if any, of the tenant or the tenant ' s legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy. This REQUIREMENT is not met as evidenced by: Based on record review, the program failed to document tenants' identified nursing facility care preferences. 1. Tenant #1, a 92 year-old, was admitted on 3-26-16 and had diagnoses of: dementia, depressive disorder, hypertension, and history of	A 093		

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
	S0355	A. BUILDING: _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT GREEN MEADOWS	6750 CORPORATE DRIVE JOHNSTON, IA 50131

(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 093	Continued From page 3 falls. Tenant #1 was staged at three on the global deterioration scale (GDS), which indicated mild cognitive decline. Tenant #1 resided in the secured dementia unit. The face sheet and service plan were reviewed. A preference for nursing facility care was not identified. 2. Tenant #2, a 91 year-old, was admitted on 2-1-16 and had diagnoses of: chronic kidney disease, hypertension, atrial fibrillation, congestive heart failure, osteoarthritis and gastroesophageal reflux disease. The face sheet and service plan were reviewed. A preference for nursing facility care was not identified. 3. Tenant #4, a 77 year-old, was admitted on 4-30-16 and had diagnoses of: dementia, depressive disorder, and hypertension. Tenant #4 was staged at six on the GDS which indicated severe cognitive decline. Tenant #4 resided in the secured dementia unit. The face sheet and service plan were reviewed. A preference for nursing facility care was not identified. The Program was unable to provide documentation of nursing facility preferences when asked.	A 093		
A 096	481-69.27(1)c Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant ' s	A 096		

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
	S0355	A. BUILDING: _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT GREEN MEADOWS	6750 CORPORATE DRIVE JOHNSTON, IA 50131

(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 096	Continued From page 4	A 096		

condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation:

69.27(1)c To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant ' s health status; and

This REQUIREMENT is not met as evidenced by:
Based on a review of four tenant files, three files lacked nurse reviews with changes of condition to assess and document the health status of the tenant and monitor progress related to previous recommendations.

1. 1. Tenant #1, a 92 year-old, was admitted on 3-26-16 and had diagnoses of: dementia, depressive disorder, hypertension, and history of falls. Tenant #1 was staged at three on the global deterioration scale which indicated mild cognitive decline. Tenant #1 resided in the secured dementia unit.

A fax dated 6-10-16 documented Tenant #1 fell on 6-6-16 and was sent to the emergency room after hitting his/her head.

A nurse review to assess and document the health status of Tenant #1 was not completed following a fall with a hit to the head necessitating a visit to the emergency room.

2. Tenant #2, a 91 year-old, was admitted on

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
	S0355	A. BUILDING: _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT GREEN MEADOWS	6750 CORPORATE DRIVE JOHNSTON, IA 50131

(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 096	Continued From page 5 2-1-16 and had diagnoses of: chronic kidney disease, hypertension, atrial fibrillation, congestive heart failure, osteoarthritis and gastroesophageal reflux disease. Progress notes dated 7-21-16 and timed 11:23 a.m. documented Tenant #2 had increased confusion and poor circulation in the feet bilaterally. Notes dated 7-21-16 and times 4:04 p.m. documented the nurse was called to the tenant's apartment because the tenant had "excessive breathing." Tenant #2 had a pulse rate of 141 and the apical pulse was irregular and "hard to count." Tenant #2 was taken to the hospital. Notes dated 7-22-16 documented Tenant #2 had been admitted to the hospital and hoped to return to the Program the following Monday. A nurse review to assess and document the health status of Tenant #2 and monitor progress, was not completed following hospitalization for confusion, poor circulation, excessive breathing, a rapid pulse rate, and irregular heart rhythm, a significant change of condition. 3. Tenant #4, a 77 year-old, was admitted on 4-30-16 and had diagnoses of: dementia, depressive disorder, and hypertension. Tenant #4 was staged at six on the (GDS)which indicated severe cognitive decline. Tenant #4 resided in the secured dementia unit. Progress notes dated 7-23-16 documented the nurse was notified by staff that Tenant #4 was found on the floor and emergency services were called as it appeared that Tenant #4 had hit his/her head. A nurse review to assess and document the	A 096		

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
	S0355	A. BUILDING: _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT GREEN MEADOWS	6750 CORPORATE DRIVE JOHNSTON, IA 50131

(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 096	Continued From page 6 health status of Tenant #1 was not completed following the incident.	A 096		

Edencrest at Green Meadows
6750 Corporate Drive
Johnston, Iowa 50131

✓ dk 9/13/16

Date: 8/30/16

Complaint Intake #: Initial certification

Plan of Correction (POC) Submitted For:

- Investigation Date:8/11/16

POC:

Regulatory Insufficiency: *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.*

Program POC:

1. **Elements detailing how insufficiency was corrected for residents**:

   All Service plans associated with the last 45 days of assessments were printed for tenants #1, #2 and #4. Signatures and dates were obtained and placed in the financial files by Aug 29, 2016

2. **Actions the program is taking to protect tenants in similar situations**:

   All resident files were audited for the last service plan update and signatures. These are in compliance as of September 6, 2016

3. **Measures taken to ensure problem does not recur:**

   The Program Nurse and Manager will audit each comprehensive assessment and Nurse Review completed to ensure the service plans have signatures on them. The date of compliance is September 6, 2016.

Regulatory Insufficiency: *481-69.26(231C) Service plans.69.26 (4) The service plan shall be individualized and shall indicate, at a minimum: e. Preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy.*

Program POC:

1. **Elements detailing how insufficiency was corrected for residents:**
   The Program Nurse obtained a nursing facility care preference for Residents #1, #2 and #4. Service plans were updated with these preferences on 8/17/16.

2. **Actions program taking to protect tenants in similar situations:**
   The Program Nurse received training on the need for the nursing facility care preference on the service plan on 8/17/16, The Program Nurse obtained a nursing facility care preference for each resident. Service plans were updated. Nursing facility care preference will be addressed with each comprehensive assessment and service plan review Sept 6, 2016.

3. **Measures taken to ensure problem does not recur:**
   Random audits will be completed to ensure all new residents have a nursing facility care preference by the Program Nurse and Manager. The date of compliance is September 6, 2016.

Regulatory Insufficiency: *481-69.27(231C) Nurse Review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation:*

69.27(1) c To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant' s health status;

Program POC:

1. Elements detailing how insufficiency was corrected for residents:

Nurse reviews were completed for Residents #1, #2 and #4 by September 6, 2016.

2. Actions program taking to protect tenants in similar situations:

Education on prn reviews was completed with the program nurse on 8/17/16. Incident reports from 8/15/26 were audited for follow up prn reviews. Any incident reports, conditions requiring antibiotics, skin issue and emergency room visits will be followed up on 1 to 10 days later.

3. Measures taken to ensure problem does not recur:

Random audits by the Program Nurse and Manager or designee will be conducted through both a QA process and auditing of the dashboard of the electronic software system. The compliance date will be September 6th, 2016.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.