4/6/17

PRINTED: 03/29/2017
FORM APPROVED

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
	S0357	A. BUILDING: _____ B. WING _____	03/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITES OF ANKENY	420 NW ASH DRIVE ANKENY, IA 50023

(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	481-69 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: 9 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 11 TOTAL census of Assisted Living Program: 11 The following regulatory insufficiency was cited during the initial visit conducted to determine compliance with certification of an Assisted Living Program.	A 000	The facility denies that the facts set forth constitute a deficiency under interpretation of Federal and State law. The preparation of the following plan of correction does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared was executed solely because the provision of State and Federal law required it.	
A 094	481-69.27(1)a 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 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: 69.27(1)a To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders.	A 094	A094-481-69.27(1)a-Nurse Review The facility has updated its tenant review form to include more specific verbiage to cue for notation of adverse reactions for program-administered prescription medications. Facility has set an agreement with consulting pharmacy for 90 day review of medications by a licensed pharmacist in addition to above. Both items above were complete as of 03-21-17 and 03-31-2017. The Program Director will monitor quarterly for continued compliance.	

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

4/6/17

PRINTED: 03/29/2017
FORM APPROVED

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
	S0357	A. BUILDING: _____ B. WING _____	03/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITES OF ANKENY	420 NW ASH DRIVE ANKENY, IA 50023

(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 094	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete 90 day nurse reviews as required for 2 of 2 tenants reviewed who received program-administered prescription medications (Tenant #1 and #2). Findings follow: 1. Review of Tenant #1's file revealed the following: a. The Service Plan dated 2-24-17 indicated the Program administered medications as ordered by the physician. b. Nurse's Notes dated 2-24-17 indicated a 90 day review was completed and referred to the nurse review under the evaluation tab. The entry did not include a review of the tenant's medications. c. The 90 day Nurse Review dated 2-24-17 did not include a review of medications administered by the program. 2. Review of Tenant #2's file revealed the following: a. The Service Plan dated 12-22-16 indicated the Program administered medications at the prescribed times. b. Nurse's Notes dated 12-22-16 indicated a 90 day review was completed and referred to the written report under the evaluation tab. The entry did not include a review of the tenant's medications. c. The 90 day Nurse Review dated 12-22-16 did not include a review of medications administered by the program.	A 094		

PRINTED: 03/29/2017
FORM APPROVED

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
	S0357	A. BUILDING: _____ B. WING _____	03/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITES OF ANKENY	420 NW ASH DRIVE ANKENY, IA 50023

(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 094	Continued From page 2 3. Interview with the Corporate Compliance Nurse on 3-20-17 at 1:12 p.m. confirmed a review of medications was not completed for either tenant and the nurse responsible for completing the reviews was no longer employed with the Program.	A 094		