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 _____	C 09/26/2017

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. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 42 Number of tenants with cognitive disorder: 13 Total Population of Program at time of on-site: 55 TOTAL census of Assisted Living Program: 55 Investigation of Complaints #69393-C and #70885-C were completed and regulatory insufficiencies were identified.	A 000	See attached POC 11/9/17	
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow their policy and	A 003		

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A 003	Continued From page 1 procedure related to medication administration, including narcotic medication, for 3 of 7 tenants reviewed. (Tenants #1, #2, and #6). Findings follow: 1. Record review of Tenant #1's file revealed a Medication Review Report, dated 5-26-17, revealed Tenant #1's order for Buprenorphine Patch weekly 10 microgram/hour. The order directed: apply one patch transdermally one time per day every Tuesday for chronic pain and remove per schedule. 1a. Review of Controlled Drug Record documents from 5-8-17 to 9-18-17 revealed Tenant #1's patches not consistently counted at each shift with the offgoing and oncoming staff. Examples included, but were not limited to, the following: a. On 6-9-17, 6-10-17, 6-19-17, 7-7-17, 7-11-17, 7-13-17, 7-14-17, 7-29-17, 8-5-17 and 8-9-17; only one count of the narcotic medication completed for the entire day on all three shifts. b. On 8-4-17, 8-10-17, 8-25-17, 9-5-17 and 9-12-17; no documented count of the patches on any shift. c. From 8-26-17 at 11:00 p.m. to 9-2-17 at 2:00 p.m.; no count completed. 1b. Continued record review revealed multiple entries which included failure to ensure two staff signed for completion of the count. Examples included, but were not limited to: a. 5-8-17 at 11:00 p.m. b. 5-9-17 at 7:00 a.m., 3:00 p.m. and 11:00 p.m. c. 5-10-17 at 7:00 a.m. d. 5-12-17 at 7:00 a.m. and 3:00 p.m.	A 003		

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A 003	Continued From page 2 e. 5-13-17 at 3:00 p.m. f. 5-15-17 at 7:00 a.m. and 3:00 p.m. g. 5-17-17 at 7:00 a.m. and 3:00 p.m. h. 5-19-17 at 3:00 p.m. i. 5-21-17 at 11:00 p.m. j. 5-22-17 at 3:00 p.m. k. 5-23-17 at 7:00 a.m. l. 5-24-17 at 7:00 a.m. m. 5-25-17 at 7:00 a.m. n. 5-26-17 at 3:00 p.m. o. 5-29-17 at 7:00 a.m. p. 5-30-17 at 11:00 p.m. 1c. Additional record review noted failure to ensure the medication administration records (MARs) and count sheets were consistently reconciled. Examples included, but were not limited to: a. On 7-25-17 the MAR noted the patch as administered; however, the Controlled Drug Record failed to include administration of the patch. Continued review of the Controlled Drug Record revealed the count reduced on 7-25-17, despite administration not reflected on the record. b. On 8-1-17 a patch was documented as administered on the MAR; however, was not documented as administered on the Controlled Drug Record. The count was not reduced on the count record; however, a discrepancy was not noted and the staff documented the amount remaining as two patches. The narcotic count sheet continued until 8-15-17 at 8:00 p.m. when the last dose of that count sheet was administered. A discrepancy in the count was not noted despite a patch being signed out on the MAR and not reduced on the count sheet. Staff initialed the accuracy of the count from 8-1-17 to 8-15-17.	A 003		

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A 003	Continued From page 3 c. On 8-29-17 a patch was documented as administered on the MAR; however, was not documented as administered on the Controlled Drug Record. d. Documentation from of a count of the patches could not be located from 8-26-17 at 11:00 p.m. to 9-2-17 at 3:00 p.m., including when it was documented on the MAR as administered. Staff documented three patches on 8-26-17 at 11:00 p.m. and three patches on 9-2-17 at 3:00 p.m., despite the documentation of the administration of the patch on 8-29-17. The entries included staff initials to verify the accuracy of the count. e. Documentation on the MAR indicated a patch administered on 9-5-17. The Controlled Drug Record reflected a patch administered on 9-4-17 at 8:00 p.m., but failed to include documentation of administration of a patch on 9-5-17 or a count of the patches on any shift on 9-5-17. Documentation on the MAR indicated a patch administered on 9-12-17. The Controlled Drug Record failed to reflect administration of the patch, or count of any patches on any shift on 9-12-17. According to the Controlled Drug Record, on 9-4-17 at 8:00 p.m. the amount remaining after the patch was administered was two. That count remained two until 9-18-17 (no time provided), which was the last entry on the record. Staff documented the accuracy of the count of two patches from 9-4-17 at 8:00 p.m. to 9-18-17, despite the MAR indication of a patch administered on 9-12-17. 2. Record review of Tenant #2's file revealed an	A 003		

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A 003	Continued From page 4 order for Hydrocodone/acetaminophen 5/325 milligram (mg), one tablet by mouth every six hours while awake for the first 48 hours and then every six hours as needed for pain, dated 9-5-17. 2a. Review of Controlled Drug Record document from 9-5-17 to 9-19-17 revealed Tenant #2's Hydrocodone/acetaminophen tablets not consistently counted at each shift with the offgoing and oncoming staff. From 9-5-17 to 9-19-17, 10 of 30 documented entries reflected a count with no medication was administered; the remaining 20 entries were documented as a count after medication administration. Review of records revealed from 9-6-17 to 9-18-17 there should have been a minimum of 36 entries noted of a count of the medication without administration, one on each shift (3 per day) for 12 days. On 9-12-17 there was no documented count of the medication on any shift. 2b. Continued record review revealed Tenant #2's MARs and count sheets not consistently reconciled. Examples included, but were not limited to: a. On 9-9-17 the Controlled Drug Receipt Record/Disposition Record indicated three doses of the Hydrocodone/acetaminophen administered at 9:35 a.m., 3:30 p.m. and 9:30 p.m. Review of the MAR reflected two doses administered. Staff reduced the count on the narcotic record. b. On 9-11-17 the Controlled Drug Receipt Record/Disposition Record reflected one dose administered at 9:35 a.m. Review of the MAR reflected one dose administered at 6:30 a.m. c. On 9-11-17 at 6:30 a.m. staff documented a count with none administered, while review of the	A 003		

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A 003	Continued From page 5 MAR reflected it administered at 6:30 a.m. with the effectiveness noted. d. On 9-13-17 the Controlled Drug Receipt Record/Disposition Record reflected two doses administered at 9:15 a.m. and 8:00 p.m. Review of the MAR reflected one dose administered. Staff reduced the count on the narcotic record. e. On 9-16-17 the Controlled Drug Receipt Record/Disposition Record reflected two doses administered at 9:37 a.m. and 8:30 p.m. Review of the MAR reflected one dose administered. Staff reduced the count on the narcotic record. 3. Record review of Tenant #6's file revealed Tenant #6 received hospice services and died on 3-5-17. The Medication Review Report, dated 2-27-17, reflected Tenant #6's orders for Morphine Sulfate Solution 10 mg/5 milliliters (ml), give 0.5 ml by mouth four times daily scheduled and Morphine Sulfate Solution 10 mg/5 ml give 0.5 ml by mouth Continued record review revealed one Controlled Drug Receipt Record/Disposition Record (two pages) for the Morphine Sulfate Solution revealed both scheduled and as needed doses were counted and administered from the same bottle. The label on the count sheet reflected Morphine Sulfate Solution, 10 mg/5 ml take 0.5 ml (1 mg) by mouth every one hour as needed for SOB/pain. The count sheet failed to reflect the label for the Morphine Sulfate Solution scheduled. Additional record review revealed the following: a. According to the Controlled Drug Record on 2-10-17, 2-11-17 at 3:00 p.m. and 11:00 p.m. and on 2-17-17 staff documented administration of 1	A 003		

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A 003	Continued From page 6 ml, despite the order for 0.5 ml. The MAR failed to reflect administration of the as needed dose on those dates. b. On 2-12-17 at 9:00 a.m. and 12:00 p.m. staff documented administration of 0.25 ml, despite the order for 0.5 ml. c. The count from 2-25-17 at 8:48 p.m. to 2-27-17 (no time provided) was not legible. d. On 2-25-17, 43.5 ml remained, but documentation on 2-27-17 (no time provided) indicated 41.5 ml remained. Record review revealed the Program's policy and procedure indicated medication would be labeled and maintained in compliance with label instructions and state and federal laws. Narcotics administered by the Program would be counted with a narcotic count sheet at the nurse's discretion. Staff would be responsible to count and record the total number of narcotics at the end/beginning of each and after the administration of any narcotics. The nurse, manager or delegate of the nurse would count and record all narcotics delivered to the Program for tenants who had medications managed on a separate flow sheet. When interviewed on 9-21-17 at 2:50 p.m. the Nurse Clinician indicated narcotic counts were completed at shift with two staff and both staff initialed. Only one staff was required to initial when the narcotic medication was administered. There were two meetings planned for staff (on 9-21-17) regarding narcotic medication administration. There were no concerns regarding medication diversions.	A 003		
A 058	481-67.9(4)a Staffing	A 058		

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A 058	Continued From page 7 481-67.9(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, at a minimum, include the following: a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure the Program's registered nurse documented a review to ensure staff were sufficiently trained within 60 days of employment for 2 of 6 staff reviewed and 2 of 3 staff reviewed hired prior to the effective date of Nurse #1 as the delegating nurse (Staff A and B). Findings follow: Record review revealed Nurse C hired on 1-5-16, changed to PRN (as needed) staff, effective 3-12-17. Nurse A, hired on 8-12-16, was listed as the delegating nurse on the ALP Entrance Form effective 3-12-17. Continued record review revealed Staff A, hired 2-8-16. Continued review of Staff A's file revealed training documentation for medication management, application of patches and glucometer training completed by Nurse C, the	A 058		

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A 058	Continued From page 8 previous delegating nurse. Staff A's file failed to include documented review of all nurse delegated tasks by the current delegating nurse. Additional record review revealed Staff B, hired 12-2-16. Continued review of Staff B's file revealed training documentation for medication management, glucometer training, inhaler assistance, whirlpool, showers, and dressing change training completed by Nurse C, the previous delegating nurse. Staff B's file failed to include training on completion of a narcotic count or application of patches. Staff B did not have a documented review of all nurse delegated tasks by the current delegating nurse. When interviewed on 9-21-17 at 12:33 p.m. Nurse A confirmed Staff A and B assisted with the tasks. During an interview with the Manager on 9-26-17 at 1:55 p.m. current delegations for Staff A and B were provided. The Manager indicated Nurse A was in process of updating the delegations.	A 058		
A 147	481-67.5(6)d Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced	A 147		

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A 147	Continued From page 9 by: Based on interview and record review the Program failed to administer medications as ordered for 4 of 7 tenants reviewed (Tenants #1, #2, #3 and #6). Findings follow: 1. Record review of Tenant #1's file revealed a Medication Review Report, dated 5-26-17, noted Tenant #1's order for Buprenorphine Patch weekly 10 microgram/hour, one patch transdermally one time per day every Tuesday for chronic pain and remove per schedule. Review of June 2017 medication administration records (MARs) indicated the patch documented as applied on 6-13-17, 6-20-17 and 6-30-17. On 6-6-17 and 6-27-17 the MAR indicated Tenant #1 was absent and the patch not administered. Additional review of Tenant #1's Controlled Drug Record reflected a patch administered on 6-9-17 at 8:00 a.m.; however, it was not reflected on the MAR. Review of May 2017 MARs reflected the last patch in May administered on 5-30-17. Further review revealed Tenant #1 did not receive the next patch until 6-9-17. The June and July 2017 MARs reflected the last patch applied in June on 6-30-17 and the next patch not administered until 7-11-17. The MAR noted Tenant #1 refused the mediation on 7-2-17. Continued record review revealed a medication error form completed for a medication error on 6-6-17. The report noted Tenant #1 was out of the building without medications and staff did not change the patch when he/she returned. No additional documentation could be located	A 147		

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A 147	Continued From page 10 regarding discrepancies in administration. 2. Record review of Tenant #2's file revealed an order for Hydrocodone/acetaminophen 5/325 milligram (mg), one tablet by mouth every six hours while awake for the first 48 hours and then every six hours as needed for pain, dated 9-5-17. Continued record review revealed the MAR and Controlled Drug Receipt Record/Disposition Record reflected the medication given at 10:00 p.m. on 9-5-17, twice on 9-6-17 at 4:00 p.m. and 10:00 p.m. and once on 9-7-17 at 7:00 p.m. The Program failed to administer the medication every six hours while awake for the first 48 hours per doctor order. 3. Record review of Tenant #3's file revealed Progress Notes, dated 5-15-17, documented staff notified Nurse #1 of a pressure area on Tenant #3's left hip. According to notes, the area was red, approximately 3 centimeters (cm) round with a brown 1 cm center. Notification to the primary care physician and a request for treatment was completed. On 5-16-17 the Program received an order to apply Duoderm daily. Further review revealed an order, received on 5-31-17, to change Duoderm every three days, according to Progress Notes dated 5-31-17. On 6-5-17 the Program received an order to discontinue Duoderm dressing and provide wound care every three days and as needed. Additional record review revealed Tenant #3's May 2017 MARs reflected the treatment not completed on 5-17-17, 5-21-17 and 5-28-17. a. Progress Notes dated 5-21-17 and 5-28-17 indicated the nurse was to complete when in the building. Documentation regarding nurse completion of the dressing change on those	A 147		

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A 147	Continued From page 11 dates could not be located. b. On 5-17-17 it was noted the Duoderm was not available. Review of June 2017 MARs reflected the dressing change not completed on 6-6-17 and 6-18-17. a. On 6-6-17 it was charted as a refusal. b. On 6-18-17 the MAR indicated the nurse would change the dressing; however, documentation of completion of the dressing change could not be located. Doctor ordered wound care was not completed as ordered. 4. Record review of Tenant #6's file revealed a Medication Review Report, dated 2-27-17, reflected Tenant #6's orders for Morphine Sulfate Solution 10 mg/5 milliliters (ml), 0.5 ml by mouth four times daily scheduled and Morphine Sulfate Solution 10 mg/5 ml give 0.5 ml by mouth every one hour as needed for shortness of breath (SOB)/pain, both with an order date of 2-9-17. Tenant #6 also had orders for Lorazepam Concentrate 2 mg/ml by mouth four times daily for agitation and pain and Lorazepam Concentrate 2 mg/ml,0.25 ml by mouth every hour as needed for anxiety/agitation, both with an order date of 2-7-17. Continued record review revealed one Controlled Drug Receipt Record/Disposition Record (two pages) for the Morphine Sulfate Solution, both scheduled and as needed doses were counted and administered from the same bottle. The label on the count sheet reflected Morphine Sulfate Solution, 10 mg/5 ml, 0.5 ml (1 mg) by mouth every one hour as needed for SOB/pain. The	A 147		

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A 147	Continued From page 12 count sheet did not reflect the label for the scheduled Morphine Sulfate Solution scheduled. a. According to the Controlled Drug Record on 2-10-17, 2-11-17 at 3:00 p.m. and 11:00 p.m. and on 2-17-17 staff documented administration of 1 ml, despite the order for 0.5 ml. Review of the MAR revealed no documentation of as needed dose. On 2-12-17 at 9:00 a.m. and 12:00 p.m. staff documented administration of 0.25 ml, despite the order for 0.5 ml. b. Record review revealed one Controlled Drug Receipt Record/Disposition Record sheet (two pages) for the Lorazepam concentrate, both scheduled and as needed doses were counted and administered from the same bottle. The label on the count sheet reflected Lorazepam Concentrate 0.25 ml, by mouth every one hour as needed for SOB/anxiety. The count sheet did not reflect the label for the scheduled Lorazepam Concentrate. According to the Controlled Drug Record on 2-10-17 at 9:50 a.m. and 2-17-17 at 11:00 p.m. staff documented 0.5 ml administered. When interviewed on 9-21-17 at 12:33 p.m. Nurse A reported scheduled and as needed doses of Tenant #6's Morphine Sulfate Solution were taken from the same bottle. She confirmed the same regarding the tenant's Lorazepam Concentrate.	A 147		
A 071	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents.	A 071		

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 _____	C 09/26/2017

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 071	Continued From page 13 69.25(1) Documentation for each tenant shall be maintained by the program and shall 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 document by exception in nurses' notes for 2 of 7 tenants reviewed (Tenants #3 and #7). Findings follow: 1. Record review revealed Tenant #3's progress notes, dated 6-28-17, indicated a note received from the doctor to discontinue an antibiotic and check Tenant #3's stool for Clostridium Difficile. The hat and specimen cup were in Tenant #3's apartment pending collection. Tenant #3 had an appointment with the primary care physician on 6-29-17, did not return to the Program, and was discharged on 6-30-17. Progress Notes failed to include follow up to the order to check Tenant #3's stool or if the specimen had been collected prior to discharge. An interview with Nurse #1 on 9-21-17 at 12:33 p.m. indicated Nurse #2 could not get a sample before Tenant #3 was discharged. 2. Record review revealed Tenant #7's Progress Notes, dated 9-16-17 (late entry), documented on the night of 9-9-17 at approximately 7:00 p.m. Nurse B received a call from staff who reported Tenant #7 in an active seizure and asking what to	A 071		

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A 071	Continued From page 14 do. Staff was informed Tenant #7 was a hospice patient and hospice needed to be called. Staff contacted hospice and received direction to call emergency medical technicians (EMTs) and notify Tenant #7's family. Staff reported Tenant #7 in active seizure while the EMTs were present. Tenant #7 was taken to a hospital and the family was informed. Continued record review revealed the following: a. Progress Notes dated 9-18-17 indicated the hospital called and reported Tenant #7 in observation with new medications. b. Progress Notes dated 9-18-17 indicated a change of condition evaluation completed due to a new diagnosis of seizures. c. September 2017 medication administration records (MARs) revealed two new medications started 9-18-17, Keppra tablet 500 milligram (mg), one dose by mouth twice daily and Levaquin tablet 500 mg, one dose by mouth, twice daily for infection. d. Progress Notes failed to accurately document when Tenant #7 went to the hospital. Further review of progress notes revealed no documentation of Tenant #7's return to the Program or orders for two new medications. When interviewed on 9-20-17 at 10:52 a.m., Nurse B revealed Tenant #7 went to the hospital on Saturday (9-16-17) at approximately 7:00 p.m. and returned on Monday (9-18-17). Nurse B explained the entry dated 9-16-17 was for 9-19-17. It was Tenant #7's first seizure and there had been no history previously.	A 071		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 089	Continued From page 15	A 089		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans to accurately reflect identified tenant needs. This pertained to 2 of 7 tenants reviewed (Tenants #3 and #4). Findings follow: 1. Record review of Tenant #3's file revealed Progress Notes, dated 4-26-17, indicated Tenant #3's family took him/her to the doctor and an order was obtained for Levaquin for a diagnosis of bronchitis. Continued record review revealed the following: a. Progress Notes dated 5-17-17 reflected a nurse review was completed related to the completion of the Levaquin for a upper respiratory infection (URI). The service plan did not reflect the URI and antibiotic treatment. b. Progress Notes dated 5-2-17 documented when Tenant #3 refused any medications after three attempts and nurse attempts, the family would be called to come try. The notes further directed staff to put a large pill in applesauce or pudding and not to talk about the size of the pill.	A 089		

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A 089	Continued From page 16 c. Review of the service plan revealed staff administered medications; however, did not reflect Tenant #3's refusals of medications and interventions or the pill in applesauce or pudding. 2. Record review revealed Tenant #3's Progress Notes, dated 5-15-17, indicated staff notified Nurse A of a pressure area on Tenant #3's left hip. The area was red, approximately 3 centimeters (cm) round with a brown 1 cm center. Notification to the primary care physician and a request for treatment was completed. On 5-16-17 the Program received an order to apply Duoderm daily. Tenant #3's family indicated the wound was a long standing wound and the doctor had x-rayed in the past and had no treatment orders before. Continued review of Progress Notes revealed the following: a. A note on 5-24-17 indicated the doctor prescribed Clindamycin 300 milligram (mg), three times per day for 10 days for possible infection. b. A note dated 5-26-17 indicated the Clindamycin was prophylaxis to prevent infection. c. A note dated 5-31-17 documented an order received on 5-31-17 to change Duoderm every three days. d. On 6-5-17 the Program received an order to discontinue Duoderm dressing and provide wound care every three days and as needed. e. A notes dated 6-28-17 indicated a new order received to discontinue the Duoderm paste and change treatment to apply skin prep and cover	A 089		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 089	Continued From page 17 with gauze dressing for 30 days. Continued record review revealed Tenant #3's service plan failed to include the wound on Tenant #3's hip. 3. Record review of Tenant #4's Progress Notes, dated 5-1-17, reflected Tenant #4 had 3+ edema, the left leg appeared larger than the right. An order was received on 5-2-17 for Ace Wraps, regarding the bilateral lower extremity edema. The wraps were ordered to be applied in the morning and removed at bedtime per Tenant #4's request. The service plan directed to elevate legs when sitting in the recliner; however, the service plan failed to reflect Tenant #4's edema and doctor ordered wraps. 4. Record review revealed Tenant #4's Progress Notes, dated 5-16-17, indicated during skin assessment it was noted Tenant #4 had a yeast infection, under both breasts and groin. The primary care physician was contacted and a prescription was requested to address the issue. Nystatin powder was called in to the pharmacy and family picked it up. A late entry in Progress Notes dated 6-1-17 reflected the yeast infection had healed. Continued record review revealed Tenant #4's task sheets. The sheet for April 2017 reflected bathing stand by assist (SBA) for safety. All attempts at bathing were documented as tenant refusal or not applicable. The task sheet for May 2017 reflected bathing SBA for safety. All attempts at bathing were documented as not applicable or not completed. The task sheet for June 2017 reflected bathing SBA for safety and all attempts were documented as not completed, tenant not available, tenant refused or not	A 089		

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A 089	Continued From page 18 applicable. Additional record review revealed Tenant #4's service plan reflected the tenant bathed on Wednesday and Saturday days and as requested. A calendar in the apartment should be signed by both Tenant #4 and staff after shower or refusal. A calendar for May 2017 reflected showers completed 5-2-17 (by therapy), 5-4-17, 5-7-17, 5-10-17, 5-13-17, 5-16-17 and 5-31-17. During the week of 5-26-17 the calendar noted Tenant #4 said he/she took a shower by himself/herself that week, but forgot to write it down. The service plan reflected Tenant #4 had a calendar to document baths; however, the service plan failed to reflect additional interventions for bathing refusals and failed to reflect the Nystatin Powder for the yeast infection. An interview with Nurse #1 on 9-21-17 at 12:33 p.m. revealed Tenant #4 was independent with the application of the Nystatin powder.	A 089		

ok 11/17/17

ok 11/17/17

Edencrest at Green Meadows
6750 Corporate Dr.
Johnston, Iowa 50131

Date: 10/24/2017

Complaint Intake #: #69393-C and #70885-C

Plan of Correction (POC) Submitted For:

- Investigation Date:

POC:

A. ***Regulatory Insufficiency:***

a. 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.

Program POC:

1. **Elements detailing how insufficiency was corrected for residents**:
   a. In regard to residents #1,2 narcotic count, doctors' orders and EMAR were reconciled by 10/6/17. Other resident narcotic orders were audited and narcotic count sheets were reconciled by 10/6/17.

2. **Actions the program is taking to protect tenants in similar situations**:
   a. Staff training was conducted on 09/21/17 and retraining was done on policy and procedures relating to narcotic counts, giving narcotics, documenting narcotics on narcotic sheets and through EMAR and how to properly sign-out narcotics.

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

a. Narcotic sheets will be audited routinely by a nurse, community manager and or designee. There will be a second training on policy and procedures as it relates to narcotics on 11/2/17.

B. ***Regulatory Insufficiency:***

a. 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, at a minimum, include the following: a.

The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated.

Program POC:

1. **Elements detailing how insufficiency was corrected for residents**:
   a. Staff A&B are no longer employed at Edencrest Green Meadows. All staff delegation will be audited by 10/27/17
2. **Actions the program is taking to protect tenants in similar situations**:
   a. Healthcare Coordinator is utilizing a new delegation packet for all new and existing resident assistants. Redelegation will be completed by 11/09/17
3. **Measures taken to ensure problem does not recur:**
   a. Healthcare coordinator will delegate new staff utilizing updated delegation packet as part of onboarding and training. Healthcare coordinator will redelegate staff as needed going forward.

C. ***Regulatory Insufficiency:***

a. 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: d. Medications shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.

Program POC:

1. **Elements detailing how insufficiency was corrected for residents**: All staff re-educated on medication administration and how to report to nursing if medications are not available. Immediate staff involved were re-delegated on medication management.
2. **Actions the program is taking to protect tenants in similar situations**: All meds are now hole punched and put together on a ring per each medication pass for each resident. Will continue to educate staff on how to report when medications are missing.
3. **Measures taken to ensure problem does not recur:** All staff are educated upon hire and when med delegated to report missing medications to nurses immediately. Nurse monitors MAR reports frequently, at least monthly to ensure meds are properly administered and documented.

D. ***Regulatory Insufficiency:***

a. 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 shall 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

Program POC:

1. **Elements detailing how insufficiency was corrected for residents**: In regard to residents 1,2,3,6 medication orders will be compared to EMAR's and adjusted accordingly by 10/27/17. All residents were audited for liquid morphine and Ativan order and none were noted.
2. **Actions the program is taking to protect tenants in similar situations**: By monitoring daily dashboard and utilizing reports. By monitoring dashboard and utilizing report by 10/27/17 healthcare coordinator and manager will monitor EMAR dashboard daily for next 30 days, with EMAR reports audited weekly and educations and feedback given to resident assistant as needed. This will be in place by 11/9/17.
3. **Measures taken to ensure problem does not recur:** Health care coordinator audits the dashboard on a weekly basis by utilizing reports. When resident have both PRN and routine liquid morphine or Ativan order. The healthcare coordinator will coordinate with the pharmacy or hospice that a spilt label is on the medication and narcotic sheet.

E. ***Regulatory Insufficiency:***

a. 481-69.26(4) a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance.

Program POC:

1. **Elements detailing how insufficiency was corrected for residents**: In regards to tenants 3,7 neither resident resides at Edencrest green meadows. Education was provided to the nurse by the nurse clinician regarding documentation of lab follow through and resident being sent to the hospital in a timely matter.
2. **Actions the program is taking to protect tenants in similar situations**: The health care coordinator and RN have developed new plan for tracking labs and on call communications from staff is tracked and documented in a timely manner. All resident outstanding labs audited and completed by 11/0917
3. **Measures taken to ensure problem does not recur:** The health care coordinator and RN have developed new plan for tracking labs and on call communications from staff is

tracked and documented in a timely manner. All resident outstanding labs audited and completed by 11/09/17

F. ***Regulatory Insufficiency:***

a. 481-69.26(4) a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance.

Program POC:

1. **Elements detailing how insufficiency was corrected for residents**:
    a. In regards to tenants 3,4 neither resident resides at Edencrest Green Meadows. Resident with skin impairments and reluctance to show or accept ISP were audited and updated accordingly.
2. **Actions the program is taking to protect tenants in similar situations**:
    a. Any new infections or disease processes on the IS and any changes to cares has to be on the ISP. This will be audited monthly by health care coordinator.
3. **Measures taken to ensure problem does not recur:**
    a. Any new infections or disease processes on the ISP and any changes to cares has to be on the ISP. This will be audited monthly by health care coordinator. Compliance date of 11/09/17

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.