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PRINTED: 11/28/2017
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
	S0296	A. BUILDING: _____ B. WING _____	11/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWATER ASSISTED LIVING	9250 EDGELINE DRIVE WEST DES MOINES, IA 50266

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs 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: 29 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 31 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 5 Number of tenants with cognitive disorder: 9 Total Population of Program at time of on-site: 14 TOTAL census of Assisted Living Program: 45 The following regulatory insufficiencies were cited during the recertification conducted to determine compliance with certification for an Assisted Living Program:	A 000	**A 000** Correction date: 12/22/17 **PLAN OF CORRECTION** This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	
A 079	481-69.25(1)q Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs)	A 079	**A 079** **PLAN OF CORRECTION** This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with A 079 Regulation 481-69.25(1)q Services Provided to Meet Professional Standards Edgewater immediately corrected the deficiency related to Tenant Documents.	Date of Correction 12/22/17

POC 12/22/17

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Emily Lubeck — TITLE: Director of assisted Living — (X6) DATE: 12/6/17

STATE FORM 6899 TL6T11 If continuation sheet 1 of 5

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A 079	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure task sheets for personal and/or health-related care were developed and completed for tenants who could not advocate for themselves. This affected 3 of 3 tenants reviewed who resided in the memory care unit (Tenants #1, #2 and #3). Finding follows: Tenant #2 had been identified by the Program as a person who consistently refused personal and/or health related care. During an interview on 11/7/17 Staff confirmed Tenant #1 refused cares on a regularly basis. Review of documentation could not indicate that last time Tenant #2 received a shower. Observations on 11/7/17 of the noon meal revealed Staff A encouraging Tenant #2 to join the other tenants for the meal. Tenant #1 did not join the group but stayed in the common area in a chair. When interviewed on 11/7/17 Staff A and B revealed the Program did not use tasks sheets. Record review revealed the Program used a form that listed all tenants who resided in the memory care unit. Further review revealed a variety of responses recorded by staff. Some entries said "OK", some listed more detailed information but staff did not consistently record personal and/or health-related care completion. When interviewed on 11/7/17 at 2:00 p.m. the Executive Director, Director of Assisted Living and Licensed Practical Nurse (LPN) A confirmed	A 079	-To correct the deficiency: 1. Program Director developed task sheets specific to each tenant residing in the Memory Care Unit and any Assisted Living tenant residing in the general population with a GDS score of 4 or higher. Task sheets for these tenants including tenants #1, #2 and #3 are complete. 2. Direct care staff will be educated on the need to provide accurate documentation to ensure personal and health related care is completed for all tenants who cannot advocate for themselves. Mandatory staff training will occur on 12/20/17 to ensure accurate and consistent use. 3. Direct care staff will be trained on use of task sheets for each individual resident. Mandatory staff training will occur on 12/20/17 to ensure accurate and consistent use. -To ensure the problem does not recur: Tenant specific task sheets have been integrated into the standard documentation protocol for tenants in memory support and those residing in the general population with a GDS score of 4 or higher. -As part of Edgewater's ongoing commitment to quality assurance: The Program Director will monitor tenant task sheets on a routine basis to ensure personal and health related care is occurring and are accurately documented on the task sheets.	

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A 079	Continued From page 2 the Program failed to ensure task sheets were developed and completed for tenants who could not advocate for themselves.	A 079		
A 091	481-69.26(4)c Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: c. The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy This REQUIREMENT is not met as evidenced by: Based on interviews and record review the Program failed to consistently ensure service plans indicated providers of occupational therapy (OT) physical therapy (PT) for 2 of 5 tenants reviewed (Tenants #4 and #6). Finding follows: Record review on 11/8/17 revealed the following: a. Tenant #4's physician's order for an occupational therapy (OT) evaluation, dated 9/22/17. Tenant #4 received an OT evaluation and services began on 9/29/17. Continued record review revealed Tenant #4's service plan failed to include OT services. b. Tenant #6's physician's order for an OT evaluation. Tenant #6 received an OT evaluation on 9/29/17 and PT evaluation on 10/6/17 and services began on each respective date. Continued record review revealed Tenant #6's service plan failed to include PT and OT services.	A 091	**A 091** **PLAN OF CORRECTION** This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with A 091 Regulation 481-69.26(4)c, Services Provided to Meet Professional Standards Edgewater immediately corrected the deficiency related to Service Plans. - To correct the deficiency: 1. Tenant# 4 and #6 have been discharged from therapy services and each service plan has been updated per tenant needs to ensure proper care and services. 2. Education provided to nursing staff on 11/09/17, 11/10/17 and11/14/17 on the requirement to include service plan documentation indicating the involvement of outside services, including but not limited to hospice care, home health care, occupational therapy and physical therapy, are required for tenants.	Date of Correction 12/22/17

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A 091	Continued From page 3 When interviewed on 11/7/17 at 2:00 p.m. the Executive Director, Director of Assisted Living and Licensed Practical Nurse (LPN) A confirmed the Program failed to ensure therapies were added to service plans.	A 091	-To ensure the problem does not recur: 1. All service plans have been reviewed and updated as necessary for the coordination of outside services for providers such as hospice care, home health care, occupational therapy and physical therapy services. 2. Program Director developed and implemented a service plan matrix to ensure service plans are routinely and promptly updated to include outside services including, but not limited to hospice care, home health care, occupational and physical therapy services. -As part of Edgewater's ongoing commitment to quality assurance: 1. The service plan matrix will be reviewed routinely by Program Director to ensure all service plans are current and include documentation of all outside services including but not limited hospice care, home health care, occupational and physical therapy.	
A 118	481-69.29(4) Staffing 481-69.29(231C) Staffing 69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans. A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews that Program failed to ensure tenants' service plans included direction to staff regarding supervision of tenants. This affected 2 of 3 tenants (Tenant #1 and #2) who resided in the memory care unit. Finding follows:	A 118	**A 118** **PLAN OF CORRECTION** This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance	

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A 118	Continued From page 4 When interviewed Staff A reported tenants' service plans did not provide direction to staff regarding how and/or when to check on tenants who resided in the memory care unit. Record review on 11/8/17 revealed Tenants #1 and #2's service plan failed to include direction to staff regarding supervision of the tenants. When interviewed on 11/7/17 at 2:00 p.m. the Executive Director, Director of Assisted Living and Licensed Practical Nurse (LPN) A confirmed the Program failed to include direction to staff regarding checking on tenants who resided on the memory care unit.	A 118	with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with A 118, Regulation 481-69.29(4) Services Provided to Meet Professional Standards Edgewater immediately corrected the deficiency related to Staffing. - To correct the deficiency: 1. All individual service plans for tenants who reside in the Memory Care unit and tenant in the general population with a GDS score of 4 or higher will be updated to include how and when staff shall provide safety checks. 2. Tenant safety monitoring will be included on the tenant specific task sheet and will be documented based on the individual service plan and tenants needs. 3. Direct care staff will be educated on the need to provide accurate documentation and monitor the safety of all tenants who cannot advocate for themselves. Mandatory staff training will occur on 12/20/17 to ensure accurate and consistent use of the task sheets. -To ensure the problem does not recur: Tenant specific task sheets have been integrated into the standard documentation protocol for tenants in memory support and those residing in the general population with a GDS score of 4 or higher. -As part of Edgewater's ongoing commitment to quality assurance: The Program Director will monitor tenant task sheets on a routine basis to ensure safety checks are being completed per the resident specific service plan.	Date of Correction 12/22/17

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