

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IAALPD339 HFD	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2020
NAME OF PROVIDER OR SUPPLIER EDENCREST AT RIVERWOODS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 EAST PARK AVENUE DES MOINES, IA 50320		
(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 for People with Dementia 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: 23 Number of tenants with cognitive disorder: 6 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 12 TOTAL census of Assisted Living Program for People with Dementia: 41 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of an Assisted Living Program and during the investigations of Complaint #88316-C and Complaint #88429-C.	A 000	See attached POC	
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This Requirement is not met as evidenced by: Based on observation, interview, and record review the Program failed to provide adequate and	A 013		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 013	Continued From Page 1 appropriate care, treatment, and services. This pertained to 8 of 8 tenants (Tenant #1, Tenant #2, Tenant #3, Tenant #4, Tenant #5, Tenant #7, Tenant #8, and Tenant #9) observed and potentially affected all 12 tenants residing in the memory care unit. Findings follow: 1. Observations on 1-26-2020 revealed the following: a. Staff I failed to appropriately engage with tenants in the living room from 3:45 p.m. to 5:00 p.m. Tenant #3, Tenant #5, and Tenant #7 slept in the living room furniture, Tenant #9 slept slumped over in her wheelchair, and 4 other tenants watched television. Staff I talked a few times to the tenant next to her and failed to engage with the other tenants as Staff C passed medications. Around 5:00 p.m. Staff I asked Staff C for assistance to transfer Tenant #5 to a standing position, walked with her to the dining room, and failed to toilet her prior to meal as required. b. Staff C served evening meal at 5:00 p.m. and failed to offer alternative food choices to all tenants. The meal consisted of chicken strips, french fries, cucumber salad, and mandarin oranges. Only a few tenants received the cucumber salad and Staff C failed to offer choice to other tenants. The Health Care Coordinator (HCC) arrived and engaged with tenants during the meal. The HCC retrieved towels from the paper towel dispenser and offered them as napkins to the tenants. Staff C, Staff I, and the HCC failed to offer condiments or milk with the meal. Three tenants had not attempted to eat their meal for over 15 minutes. Staff C stated "time to eat" to Tenant #5 and failed to offer appropriate encouragement and assistance to eat their meal.	A 013		

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A 013	Continued From Page 3 checks on Tenant #1 as required from 9-10:30 a.m. The Life Enrichment Coordinator placed an uncovered meal in his room at 12:20 p.m. and failed to inform him his meal arrived. Staff C arrived in his room approximately 20 minutes later and he remained in bed and food remained uneaten. She told him lunch was here and he got up to eat. Staff C failed to encourage him to use the restroom as required, failed to ensure his room remained clean and odor free, and failed to offer to warm up his meal. Tenant #1 was asleep in bed at 2:45 p.m. and food was all over his bed. His lunch plate remained on his table and his room continued to have a noticeable odor of urine. Staff F refilled his water at 3:00 p.m. and failed to encourage him to use the restroom as required. Staff F returned shortly to clean the mess and change sheets on his bed. d. Tenant #5 sat at the dining room table for breakfast at 9:00 a.m. and over half of the meal remained on her plate with a full glass of water in front of her. Staff failed to offer appropriate encouragement and assistance to to Tenant #5 to consume her meal and failed to encourage fluids. e. The Life Enrichment Coordinator arrived at 10:27 a.m. and provided coffee and a snack to the tenants. Two tenants had the snack item in their hands until moving to the dining area. Staff failed to encourage tenants to eat their snack or encourage fluids. f. Staff C, Staff E, and the Life Enrichment Coordinator moved tenants to the dining room for	A 013		

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A 013	Continued From Page 4 lunch at 12:11 p.m.. They served tenants the food provided by the kitchen and failed to offer alternative menu options to each tenant and failed to offer condiments. The menu consisted of chicken, rice, mixed vegetables, and strawberry shortcake. Tenant #9 proceeded to eat her rice by scooping it with her hands. Staff C offered Tenant #9 a fork, attempted one time to assist hand over hand, then stopped when she resisted. Tenant #5 proceeded to use her fingers and attempted to pick up the rice and was not able to do so. She then proceeded to pick up the pieces of chicken. Staff E sat at the table and failed to offer appropriate encouragement or assistance to Tenant #5 or Tenant #9 to eat their meals or drink fluids. Staff failed to take Tenant #3 or Tenant #9 to the restroom from 9:00 a.m. until after 1:15 p.m. 3. Observations on 1-28-2020 revealed the following: a. The memory care unit had a noticeable odor of urine. b. Tenants located in the living room were unattended and slept most of the time from 1:30 p.m. to 4:45 p.m.. c. Staff failed to toilet Tenant #3, Tenant #5, Tenant #7, and Tenant #9 as required. d. Staff failed to complete hourly checks on Tenant #1 and other tenants that remained in their rooms as required.	A 013		

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A 013	Continued From Page 2 At 5:45 p.m. Tenant #3 had consumed her oranges and a few french fries, Tenant #5 had consumed only her bread and one chicken strip, and Tenant #8 consumed one half of a chicken strip and half of her oranges. Staff I remained in the kitchen during most of the meal and the HCC talked to tenants during the meal and failed to offer appropriate encouragement and assistance to eat their meals. Staff C and Staff I left to assist another tenant in his room and the HCC remained in the dining room. Five tenants continued to have a significant amount of food on their plate as of 6:00 p.m.. Tenant #3 consumed half of her meal and drank some coffee and water, Tenant #5 and Tenant #9 consumed no liquids and less than half of their meal. Staff failed to offer alternative food choices prior to removing tenants from the dining room table. 2. Observations on 1-27-2020 revealed the following: a. The Life Enrichment Coordinator arrived at 9:28 a.m. and gathered six tenants for exercise. The activity started at 9:43 a.m. and ended at 10:00 a.m.. The Activity Director failed to engage three tenants that slept during the activity. b. Three tenants were not provided their eyeglasses and wore soiled clothing. Family members asked Staff E for eyeglasses when they arrived for a visit. Tenant #6 wore the same outfit from the day before. c. Tenant #1 remained in his room throughout the day and his room had a noticeable odor of urine. Staff E entered his room around 10:30 a.m. to gather laundry and failed to apply any deodorizing product in his room. Staff C and Staff I failed to complete hourly	A 013		

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A 013	Continued From Page 5 e. The Assistant Manager arrived to assist with serving lunch and left at 12:28 p.m. and failed to offer appropriate encouragement or assistance to tenants. Staff served lunch and again failed to offer alternative food choices or condiments and failed to serve drinks until after all meals had been served. f. Tenant #3, Tenant #5, Tenant #7, and Tenant #9 failed to be taken to the bathroom from 1:45 p.m. to 4:45 p.m. g. Staff also failed to complete hourly checks on Tenant #1 and Tenant #2 as required. Record review of menus for January 26-28, 2020 revealed milk was required to be part of all three meals served. Additional record review of current Service Plans revealed the following: a. Hourly checks were required for all tenants in the memory care unit. b. Tenant #1, Tenant #3, Tenant #5, Tenant #7, and Tenant #9 required toileting cares to be completed at least every 2 hours. c. Tenant #3, Tenant #5, and Tenant #9 required staff to encourage fluids throughout the day and Tenant #9 required Ensure meal supplement offered as needed. Record review of Tenant #9's Weights and Vitals Summary revealed she weighed 114 pounds on 1-31-19 and weighed 100.8 pounds on 12-3-19. Interviews with various tenants' family members intermittently from 1-26-20 - 1-28-20 revealed	A 013			

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A 013	Continued From Page 6 meals rarely included milk and most of the time water was the only thing served. They stated most staff failed to offer assistance to tenants to eat their meals. They felt obligated to offer assistance during mealtime by dishing up and serving the food to the tenants. They also stated they would feed tenants that were not family just so they would eat. They stated they felt the memory care unit was grossly understaffed and most of the time only one staff worked the entire shift and could not possibly do a sufficient job taking care of every tenant. Families expressed concern that staff were not toileting people as they should and showers were not completed. They expressed concerns regarding the cleanliness and sanitation of the furniture as they have witnessed urine stains after meals. They stated a strong urine odor was noticeable from the furniture. When interviewed on 1-29-2020 at 11:13 a.m. Staff A stated more help is needed and one person is not able to complete all required duties for the twelve tenants in the memory care unit. She stated she called the HCC for assistance when a tenant refused care and would be instructed to call his family and failed to offer assistance. She stated there had never been this many staff in the memory care unit prior and activities were rarely completed. She confirmed families assisted with meals when she was the only staff working. She stated she tried doing the best she could but more staff were needed in the memory care unit. She stated she felt other staff did not always get showers completed and noticed tenants had an odor when she returned from her days off. When interviewed on 1-28-2020 at 10:50 a.m. Staff B stated one staff usually worked in the memory care unit. She reported one staff could not get everything done. She stated staff can call	A 013			

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A 013	Continued From Page 7 for assistance but help does not always come. When interviewed on 1-28-2020 at 5:02 p.m. the Health Care Coordinator (HCC) stated staff called her for assistance when tenants needed to be toileted. She told them she does not have the time and has her own job to do. The HCC confirmed a minimum of two staff were necessary to complete required care. During an additional interview at 5:40 p.m. she stated she was not aware staff were allowed to feed tenants in an assisted living. She stated she did not expect tenants to go hungry and failed to offer a reasonable solution if the tenant refused to eat and refused hand over hand assistance. When interviewed on 1-28-2020 at 5:14 p.m. the Manager confirmed the memory care unit required more than one scheduled staff. When interviewed on 1-28-2020 at 5:22 p.m. the Clinical Quality Manager confirmed she recognized the need for more staff and stated she was in the process of updating the schedule with additional staff. When interviewed on 1-28-2020 at 5:46 p.m. the HCC stated she could smell the urine from the dining room chairs and confirmed "they really stink." When interviewed on 2-3-2020 at 2:30 p.m. the Manager confirmed she requested new furniture for the memory care unit. She stated tenants have a hard time getting up from couches and the fabric on the dining room chairs have a noticeable urine odor and need to be replaced.	A 013		

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A 055	Continued From Page 8	A 055		
A 055	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This Requirement is not met as evidenced by: Based on observation, interview, and record review the Program failed to provide a sufficient number of staff to meet the needs of tenants. This pertained to 4 of 4 tenants (Tenant #1, Tenant #2, Tenant #5, and Tenant #9) reviewed and potentially affected all 12 tenants residing in the memory care unit. Findings follow: (See 67.3(2) for additional information) 1. Observations of six meals from 1-26-20 - 1-28-20 revealed Tenant #5 and Tenant #9 required over an hour to eat their meal. Staff failed to offer tenants appropriate assistance. Tenant #1 and Tenant #2 ate meals in their rooms. 2. Observations on 1-28-2020 revealed the memory care unit had a noticeable odor of urine. 3. Observations on 1-28-20 from 1:30 p.m. - 4:45 p.m. revealed tenants located in the living room were unattended and slept most of the time. Staff failed to assist with toilet cares for Tenant #3 and Tenant #9 and failed to complete hourly checks on Tenant #1 and other tenants that remained in their rooms. When interviewed on 1-28-2020 at 10:41 a.m. Staff B stated she was not able to get things done by herself. She confirmed one staff was assigned	A 055		

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A 055	Continued From Page 9 to the memory care and one staff was assigned as a float between the areas. The float staff would be called to assist at lunch and would not always come over to assist. They were also responsible for meal clean up. Tenant #1 at times required a significant amount of time from staff due to routine refusals and unmanageable incontinence. Tenant #5 at times required two staff for transfers. She stated she rearranged baths to another day due to lack of assistance and ran out of time to complete them. She stated the float staff and nurse fail to respond when requested to help. Activities were not done and tenants spent most of the day sleeping because she was busy with medication administration. She stated extra staff were scheduled that particular day (1-28-20) and they never had that much help available. When interviewed on 1-29-2020 at 11:13 a.m. Staff A stated more help was needed in the memory care unit. She stated she tried to get everything done but it was not always possible to do so. She stated one time she called the nurse when Tenant #1 failed to cooperate with care and was told to contact the family for help. The nurse offered no assistance. She stated she stopped calling for assistance because help was never sent when needed. She stated she was too busy and no time was available for activities. She stated her basic responsibilities included: hourly checks of tenants, toileting of tenants every two hours, administration of medications, and serving meals. She confirmed family members assisted with serving meals and helped tenants eat their meals. She stated she "can't do it all myself." Record review of Service Plans revealed hourly checks were required for all tenants in the memory care unit. Continued review revealed Tenant #1, Tenant #2, Tenant #5, and Tenant #9 were required to be toileted at least every two	A 055		

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A 055	Continued From Page 10 hours. Review of the Entrance Form indicated 1.5 staff were assigned to the memory care unit and 1.5 staff were assigned to the assisted living unit. When interviewed at various times from January 26-28, 2020 various family members of tenants stated most staff failed to offer assistance to tenants to eat their meals. They felt obligated to offer assistance during mealtime by dishing up and serving the food to the tenants. They also stated they would feed tenants that were not family just so they would eat. They stated they felt the memory care unit was grossly understaffed and most of the time only one staff worked the entire shift and could not possibly do a sufficient job taking care of every tenant. Families expressed concerns that staff were not toileting the people as they should and showers were not completed. They stated concerns regarding the cleanliness and sanitation of the furniture as they have witnessed urine stains after meals. They stated a strong urine odor was noticeable from the furniture. When interviewed on 1-28-2020 at 5:02 p.m. the HCC stated staff called her for assistance when tenants needed to be toileted and she told them she did not have the time and had her own job to do. The HCC confirmed a minimum of two staff were needed to complete care as required. At 5:40 p.m. she confirmed tenants took a long time to eat and would benefit from staff assistance. When interviewed on 1-28-2020 at 5:14 p.m. the Manager confirmed the memory care unit required more than one scheduled staff and one float staff. When interviewed on 1-28-2020 at 5:22 p.m. the Clinical Quality Manager confirmed she	A 055		

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A 055	Continued From Page 11 recognized the need for more staff and stated she was in the process of updating the schedule with additional staff.	A 055		
A 063	481-67.9(4)f 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, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This Requirement is not met as evidenced by: Based on observations, interview, and record review the Program failed to provide services in accordance with training provided. This pertained to 1 of 6 staff reviewed (Staff C). Findings follow: 1. Observation on 1-27-20 at 9:28 a.m. revealed Staff C left Tenant #6's room with gloves on her hands. She served a snack and juice to two tenants. Staff C failed to remove the contaminated gloves and wash hands prior to serving food items. Continued observation at 10:45 a.m. revealed Staff C attempted vitals on a tenant who refused. Staff C proceeded to Tenant #2 and administered 5 milligrams of Memantine. Staff C failed to wash her hands prior to handling his medication and failed to review the Medications Administration Record prior to administering medication. Additional observation at 12:15 p.m. revealed Staff C left Tenant #7's room with gloved hands carrying	A 063		

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A 063	Continued From Page 12 a soiled Depends in a clear garbage bag. She walked to the dining room pulled out a chair, Tenant #7 sat down, and Staff C pushed the chair to the table with the contaminated glove. Staff C walked to Tenant # 4's room with the garbage bag and placed it on the floor. Staff C failed to change gloves and wash hands before she opened the medication drawer. She proceeded to put medication into a cup and placed it on the counter. Tenant #4 asked for her boots and Staff C looked through dirty laundry and handled several shoes and a broom during the search. She proceeded to hand the medication and a bottle of water to the tenant with the contaminated gloves. Staff C left the room, walked to the kitchen, threw away the garbage bag, removed her gloves, and failed to wash her hands. She walked to Tenant #10's room, failed to wash her hands, and put on new gloves. She stood next to Tenant #10, grabbed the waistband of her pants, and assisted her to a standing position. Staff failed to remove gloves and wash hands and walked to Tenant# 11's apartment to administer medications. She opened the medication drawer with the contaminated gloves and was stopped at this time. Record review of Nursing Delegations on 1-28-2020 revealed the Health Care Coordinator reviewed Medication Management Agreement with Staff C on 9-5-19. The Agreement indicated staff were required to read the MAR and prescribed medication label to ensure the right resident, drug, dose, time, route/method, and documentation of medication administered. Continued review of Medication Management Agreement indicated medications should be administered within one hour before or after scheduled time on the MAR. Further review indicated hands must be washed before and after each tenant or use hand sanitizer if not visibly dirty or had no contact with any fluids. Staff should never reuse gloves and must apply	A 063		

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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
A 063	Continued From Page 13 new gloves prior to completing care with another tenant. Record review of Tenant #2's MAR revealed an order for 5 milligrams of Memantine to be administered at 9:00 a.m. When interviewed on 1-27-2020 at 11:45 a.m. Staff C stated Tenant #2 refused to take his Memantine at 9:00 a.m. Staff C refused to explain why she waited two hours to try again to administer the medication or why she did not wash her hands. When interviewed on 1-27-2020 at approximately 12:30 p.m. Staff C stated she changed her gloves and refused to explain why she failed to wash her hands or change her gloves as required. When interviewed on 1-28-2020 at 5:02 p.m. the Health Care Coordinator confirmed staff were required to change gloves and wash or sanitize hands each they assist a tenant. She stated when a tenant refused a medication she expected staff to reapproach the person a short time later and stated waiting two hours was not acceptable. She stated staff should always refer to the MAR prior to administering medications.	A 063			
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	A 089			

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A 089	Continued From Page 14 This Requirement is not met as evidenced by: Based on observation, interview, and record review the Program failed to develop service plans to indicate tenant's identified needs and preferences. This pertained to 3 of 6 tenants reviewed (Tenant #1, Tenant #2, and Tenant #12). Findings follow: 1. Record review on 2-3-2020 revealed Tenant #1's file indicated he resided in the memory care unit and required assistance with bathing, dressing, incontinence care, and medications. Continued record review revealed a 90 Day Review dated 1-19-2020 indicated he frequently refused assistance with activities of daily living (ADLs) and medications. During an observation on 2-3-2020 at 9:03 a.m. and 3:14 p.m. Tenant #1 smeared feces on himself and his surroundings and required two staff to clean up each occurrence. Further review of Tenant #1's service plan dated 9-30-19 revealed the plan was not updated to include interventions for refusals of ADLs, medications, and unmanageable incontinence. When interviewed on 2-3-2020 at 9:03 a.m. Staff A and Staff B stated Tenant #1 frequently smeared feces and he refused care and medications at times. When interviewed on 2-3-2020 at 3:14 p.m. Staff D confirmed Tenant #1's episodes of smearing feces had increased in frequency. When interviewed on 2-4-2020 at 2:42 p.m. the Health Care Coordinator stated she was not aware of the episodes of smearing feces. The HCC confirmed Tenant #1's service plan failed to	A 089		

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A 089	Continued From Page 15 include refusals of ADLs and medications. 2. Record review on 2-3-2020 revealed Tenant #2's service plan indicated he was independent with eating meals and sat in the dining room for all meals. During observations from 1-26-2020 to 2-4-2020 Tenant #2 ate all meals in his room and required assistance at times to eat. On 2-10-2020 at 10:00 a.m. the HCC confirmed Tenant #2's service plan failed to appropriately identify his needs. 3. During an observation of medication administration on 2-4-2020 at 7:30 a.m. Staff G crushed Tenant #12's medications, handed them to her, and observed her swallow them. Record review on 2-4-2020 revealed Tenant #12's service plan and Medications Administration Record (MAR) for January 2020 failed to include instructions to crush medications. When interviewed on 2-4-2020 at 7:40 a.m. Staff G stated she always crushed Tenant #12's medications. Staff G confirmed she could not find the instructions to do so on the MAR or Tenant #12's service plan. When interviewed on 2-4-2020 at 9:16 a.m. the HCC reported Tenant #12 had an order to crush medications. She confirmed the order was not included on the MAR or Tenant #12's service plan.	A 089		

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A 096	Continued From Page 16	A 096		
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 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; This Requirement is not met as evidenced by: Based on interview and record review the Program failed to assess and document tenants' health status and make recommendations and referrals as appropriate, at least every 90 days . This pertained to 1 of 1 tenants (Tenant #1) with a hospitalization and routine refusals. Findings follow: Record review on 2-3-2020 revealed Tenant #1's diagnoses included type 2 diabetes, Alzheimer's disease, syncope and collapses, and history of falling. Tenant #1 scored five on the Global Deterioration Scale (GDS), which indicated early dementia. He resided in the memory care unit. Continued record review revealed Tenant #1's Progress Notes included a 90 Day Review completed 8-27-19. Continued review revealed change of condition assessments completed	A 096		

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A 096	Continued From Page 17 9-30-19 after he returned from a hospital stay and on 10-22-19 for end of therapy services. Additional review revealed a 90 Day Review dated 1-19-2020 failed to include a review of his hospital stay, therapy services, appropriateness of interventions for routine refusals of personal cares and medications including glucose monitoring for diagnosis of diabetes, and unmanageable incontinence. Record review revealed a physician's order, dated 11-6-19, directed Tenant #1's blood sugars to be taken on Monday and Thursday at 8:00 a.m. and results to be documented. Review of Medication Administration Record for December 2019 and January 2020 revealed routine refusals of blood sugars. On 2-3-2020 during the morning shift Staff A, Staff B, Staff H confirmed Tenant #1 smeared feces on himself and his surroundings. Staff reported this happened frequently. During the afternoon shift Staff G stated she just finished cleaning him up after he again smeared feces on himself and his surroundings. She reported it happened frequently. During an observation of Tenant #1 on 2-4-2020 at 3:14 p.m. a substantial amount of fecal matter was present on his left hand and a strong offensive odor was present as a result of his unmanageable incontinence. When interviewed on 2-3-2020 at 2:42 p.m. the Health Care Coordinator (HCC) stated staff failed to inform her of the unmanageable incontinence. The HCC further reported a family member assisted with taking blood sugars when she visited.	A 096		

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A 102	481-69.28(3)c Food Service 481-69.28(231C) Food service. 69.28(3) Menus shall be planned to provide the following percentage of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences based on the number of meals provided by the program: c. One hundred percent if the program provides three meals per day. This Requirement is not met as evidenced by: Based on observation, interview, and record review the Program failed to provide 100% of the daily recommended dietary allowances for three meals served per day. This affected 12 of 12 tenants in the memory care unit. Findings follow: Observations from 1-26-2020 through 1-28-2020 revealed the kitchen failed to provide milk for all meals served. The refrigerator in the memory care unit failed to include a supply of milk available. Observations on 1-27-2020 through 1-2-2020 revealed the kitchen failed to include fruit for the morning meals and failed to include bread as part of the noon meals. Record review on 1-29-2020 revealed the Nutritional Analysis by Day/M meal revealed milk listed for all three meals served, fruit listed for breakfast, and a bread basket listed for noon meals 1-27-20 - 1-29-20 as part of the daily nutritional requirement. When interviewed on 1-28-2020 at various times several family members stated the Program rarely served milk. Family stated tenants received water	A 102			

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A 102	Continued From Page 19 and sometimes juice or coffee, breakfast rarely included fruit, and noon meals rarely included a bread option. When interviewed on 1-29-2020 at 3:28 p.m. the Culinary Coordinator stated he failed to include milk on the food cart and expected staff in the memory care unit to provide milk to the tenants. He stated he based menus off of menus provided by food service company except for breakfast. He stated he did not know meals served must meet daily nutritional requirements.	A 102		
A 108	481-69.28(6)a Food Service 481-69.28(231C) Food service. 69.28(6) Programs engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and shall be licensed pursuant to Iowa Code chapter 137F. The department will not require the program to be licensed as a food establishment if the program limits food activities to the following: a. All main meals and planned menu items must be prepared offsite and transferred to the program kitchen for service to tenants. This Requirement is not met as evidenced by: Based on observation and interview the Program failed to meet the standards of state and local health laws pertaining to the preparation and service of food. This affected 12 of 12 tenants in the memory care unit. Findings follow: Observations of meals from 1-26-2020 through 1-28-2020 revealed the following:	A 108		

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A 108	Continued From Page 20 1. On 1-26-2020 kitchen staff brought the food storage unit to the memory care unit for the evening meal around 5:00 p.m. The food cart had visible dried food spatters and debris on the top, sides, and shelves of the cart. 2. On 1-27-2020 the food cart arrived with the same, and more, dried food spatters/debris on the top, sides, and shelves of the cart for all three meals served. 3. On 1-28-2020 the food cart continued to have the same, and more, dried food spatters/debris on the top, sides, and shelves of the cart for the noon meal. Record review of Iowa Food Code 4-601.11 on 1-28-2020 revealed all nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 1-26-2020 through 1-28-2020 staff and family members interviewed at various times confirmed the food cart arrived with food spatters and debris almost daily. On 1-29-2020 at 3:28 p.m. the Culinary Coordinator stated he tried to clean the food cart once a week. The Culinary Coordinator further reported a lack of knowledge regarding the Iowa Food Code and standards of cleanliness of nonfood contact surfaces.	A 108		
A 149	481-69.34(1) Activities 481-69.34(231C) Activities. 69.34(1) The program shall provide appropriate activities for each tenant. Activities	A 149		

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A 149	Continued From Page 21 shall reflect individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skills by providing opportunities for a variety of types and levels of involvement. This Requirement is not met as evidenced by: Based on observations, interview, and record review the Program failed to provide appropriate activities for each tenant. This affected 12 of 12 tenants in the dementia unit. Findings follow: Intermittent observations in the dementia unit from January 27-29, 2020 revealed staff failed to consistently engage tenants in activities. 1. On 1-27-20 Staff C sat with tenants at 10:20 a.m. and scrolled on her work tablet for approximately 20 minutes. Occasionally the television played children's shows and at times music was played. The Life Enrichment Coordinator arrived on 1-27-2020 and conducted the following activities: a. At 9:45-10 a.m. she conducted exercises with tenants in the living room and failed to encourage tenant participation. b. At 10:30-10:45 a.m. she offered coffee to most of the tenants and read a newspaper. c. At 1-1:15 p.m. she painted nails of one tenant and stated she had to leave to lead an activity in the assisted living unit. b. Intermittent Observations on 1-29-20 from 9:00 a.m to 11:45 a.m. and 1:00 p.m.-3:00 p.m. revealed staff failed to engage Tenant #5, Tenant #7, and Tenant #9 and allowed them to sleep most of the time while in the living room. Staff failed to offer activities Tenant #1, Tenant #2, Tenant #7,	A 149		

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A 149	Continued From Page 22 and Tenant #8 located in their rooms. On 1-29-2020 a review of the activity calendar for the memory care unit revealed six scheduled activities from 8:00 a.m. to 2:00 p.m.. When interviewed at various times from January 27-29, 2020 several family members confirmed staff failed to actively engage tenants in scheduled activities. They stated the television would be on or staff offered coloring books to the tenants that required no assistance. They stated only one staff would be scheduled to the memory care unit and did not have the time for activities in addition to required duties. They stated the Life Enrichment Coordinator rarely did activities in the memory care unit. When interviewed on 1-28-2020 at 10:41 a.m. Staff B confirmed activities failed to be completed due to lack of staff. Tenants typically slept most of the time or listened to television or music. She stated one staff worked the memory care unit and would be busy with normal duties of passing medications and completing cares. She stated the Life Enrichment Coordinator failed to conduct activities in the memory care unit. When interviewed on 1-29-2020 at 11:13 a.m. Staff A confirmed one staff would be scheduled for memory care with a float staff available at times and activities were prioritized last. When interviewed on 2-4-2020 at 12:40 p.m. the Life Enrichment Coordinator confirmed she rarely conducted activities in the memory care unit. She stated she started her position a few months ago and had not taken the time to get to know the tenants. She stated staff regularly conducted the hydration and spa activities. She stated the hydration activity was defined as encouraging		A 149		

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A 149	Continued From Page 23 tenants to drink fluids and spa activity encouraged tenants to brush their teeth. She stated she never tried to include tenants from the memory care unit with activities offered in the assisted living area. When interviewed on 1-28-2020 at 5:14 p.m. the Manager confirmed the memory care unit lacked an appropriate number of staff to ensure tenants participated in appropriate activities.	A 149		
A 154	481-69.35(1)b Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This Requirement is not met as evidenced by: Based on observation, interview, and record review the Program failed to ensure furniture was clean and sanitary. This potentially affected all tenants in the dementia unit (census 12). Findings follow: Observations in the memory care unit from January 26 -29, 2020 revealed staff moved tenants to the dining room from the living room without first taking them to the bathroom. Chairs in the dining room were noticeably soiled, stained, and emitted a strong odor consistent with urine. When interviewed on 1-27-20 family members stated they observed tenants with wet clothing sitting in the dining chairs and stated the chairs often smelled of urine when they sat at the table. When interviewed on 1-28-2020 at 5:46 p.m. the Health Care Coordinator confirmed she noticed a very strong smell of urine while sitting in the dining	A 154		

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A 154	Continued From Page 24 room chair. When interviewed on 2-3-2020 at 2:30 p.m. the Manager confirmed the need to replace furniture in the memory care unit. She stated fabric covered chairs are not appropriate with people that are incontinent and hold urine odor.	A 154			

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**Edencrest at Riverwoods
2210 E. Park Ave
Des Moines, IA 50320**

Date: May 8, 2020

Complaint Intake #: 88316-C, 88429-C, and Re-Certification

Plan of Correction (POC) Submitted For:

- Investigation Date: January 26 – February 10, 2020
- Monitors: Mary Hildreth

A. Regulatory Insufficiency: 481-67.3 **Tenant Rights:** All tenants have the following rights: To Receive care, treatment, and services which are adequate and appropriate. 481-67.3 (2) The program failed to provide adequate and appropriate care, treatment, and services to tenants in a dementia unit.

1. Elements Detailing the programs correction of the insufficiencies:

- a. Staff received re-education on infection control processes and procedures. Daily audits for hand hygiene, glove use, infection control practices are being completed by the manager and/or designee, these audits started on January 29, 2020.
- b. New furniture was ordered on March 15, 2020 delivery date undetermined at this time related to COVID 19 Pandemic, however, will be put in place in memory care, once it arrives. The new furniture can be cleaned and sanitized.
- c. All condiments will be placed on the table top each meal, effective immediately in memory care.
- d. Anytime menu with pictures in place in memory care, available for tenants to pick other meal options, as needed, effective immediately.
- e. Daily log implemented to ensure tenants have condiments and anytime menu offerings, effective immediately.
- f. Coordinator team made available for assistance during mealtime in memory care as needed, effective immediately.
- g. New Activities Director hired, activities are completed as scheduled per the activity calendar, effective immediately.
- h. Staff education completed regarding meal assistance for residents with dementia on February 20, 2020.

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

- a. Random audits will be completed daily for 90 days, then weekly, and/or monthly as needed as determined by the Manager/RN or designee to ensure compliance.

3. Measures taken to ensure problem does not reoccur:

- a. Manager and/or designee will ensure new employees receive training on tenant rights and dementia upon hire and at a minimum annually.

4. Program plans to monitor performance to ensure solutions are permanent:

- a. Manager and/or designee will monitor that solutions implemented are in place: weekly, monthly, as needed as determined by the Manager/RN or designee to ensure compliance.

B. Regulatory Insufficiency: 481-67.9(1) **Staffing.** 481-67.9(231B, 231C, 231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

1. Elements Detailing the programs correction of the insufficiencies:

- a. The program has altered staffing patterns to meet the needs of the tenants, effective January 28.

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

- a. Random audits being completed daily, weekly, monthly as needed as determined by the Manager/RN or designee to ensure adequate staffing.

3. Measures taken to ensure problem does not reoccur:

- a. Manager/RN or designee will ensure that evaluations are completed on residents if a change of condition is noted as needed to assure the needs of residents is met.

4. Program plans to monitor performance to ensure solutions are permanent:

- a. Manager and/or designee will monitor that solutions are in place weekly, monthly, as needed, as determined by the Manager/RN or designee to ensure compliance.

C. Regulatory Insufficiency: 481-67.9(4)f **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, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided.

1. Elements Detailing the programs correction of the insufficiencies:

- a. Staff received education on infection control. Daily audits for infection control and hand hygiene are being completed by the manager and/or designee, since January 29, 2020.
- b. All staff attended medication management on February 20, 2020.
- c. RN, Health Care Coordinator was disciplined and put on a performance improvement plan and later terminated by the community. New RN, Health Care Coordinator has been hired.
- d. Staff C was disciplined and terminated on January 26, 2020.

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

- a. Random audits being completed daily, weekly, monthly as needed, as determined by the Manager/RN or designee to ensure services are being provided in accordance with the training received.

3. Measures taken to ensure problem does not reoccur:

- a. Manager/RN or designee will ensure that evaluations are completed on residents as needed: if a change of condition is noted a comprehensive assessment and updates to the plan of care will be completed to assure the needs of residents are being met.

4. Program plans to monitor performance to ensure solutions are permanent:

- a. Manager and/or designee will monitor that solutions are in place weekly, monthly, as needed, as determined by the Manager/RN or designee to ensure compliance.

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

1. Elements Detailing the programs correction of the insufficiencies:

- a. Health Care Coordinator was initially placed on a performance improvement plan which resulted in her termination, effective March 30, 2020. New experienced Health Care Coordinator has been hired.
- b. RN/Health Care Coordinator updated service plans for tenant's #1, #2, and #12 to reflect their needs and preferences accurately.

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

- a. As resident's conditions change, service plans will be updated with their needs and preferences and change of condition comprehensive assessments will be completed as needed by the Nurse/Health Care Coordinator.

3. Measures taken to ensure problem does not reoccur:

- a. Manager/RN or designee will ensure that evaluations are completed on residents as needed: if a change of condition is noted a comprehensive assessment and updates to the plan of care will be completed to assure the needs of residents are being met.

4. Program plans to monitor performance to ensure solutions are permanent:

- a. Manager/Health Care Coordinator and/or designee will monitor that solutions implemented are in place weekly, monthly, as needed, as determined by the Manager/RN or designee to ensure compliance.

E. Regulatory Insufficiency: 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 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 the previous recommendations at least every 90 days and whenever a there are changes in the tenant's health status.

1. Elements Detailing the programs correction of the insufficiencies:

- a. Health Care Coordinator was initially placed on a performance improvement plan which resulted in her termination, effective March 30, 2020. New experienced Health Care Coordinator has been hired. Health Care Coordinator and/or other nurse will ensure assessments and reviews of tenant's health status are completed as needed for significant changes in condition and at least every 90 days.

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

- a. As resident's conditions change, service plans will be updated with their needs and preferences and change of condition comprehensive assessments will be completed as needed by the Nurse/Health Care Coordinator.

3. Measures taken to ensure problem does not reoccur:

- a. Health Care Coordinator/Nurse will ensure that evaluations are completed on residents as needed: if a change of resident's condition is noted a comprehensive assessment and updates to the plan of care will be completed to assure the needs of residents are being met.

4. Program plans to monitor performance to ensure solutions are permanent:

- a. **Manager/Health Care Coordinator and/or designee will monitor that solutions implemented are in place weekly, monthly, as needed, as determined by the Manager/RN or designee to ensure compliance.**

F. Regulatory Insufficiency: 481-69.28(3)c **Food Service.** 481-69.28(231C) Food Service. 69.28(3) Menus shall be planned to provide the following percentages of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences based on the number of meals provided by the program: c. One hundred percent if the program provides three meals per day.

1. Elements Detailing the programs correction of the insufficiencies:

- a. New Culinary Coordinator was hired.
- b. Culinary Coordinator will utilize Martin Bros menu's, per dietician to ensure all daily requirements are being met.
- c. Culinary Coordinator will assure milk and other beverages are available in Memory Care each day for every meal.

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

- a. Random audits will be completed for daily, weekly, and monthly by the manager and/ or designee.

3. Measures taken to ensure problem does not reoccur:

- a. New Culinary Coordinator has been hired. Culinary Coordinator and Culinary staff received re-training related to cleanliness of equipment and meal service items.
- b. Culinary Coordinator works closely with Martin Bros Dietician to ensure we are meeting requirements.

4. Program plans to monitor performance to ensure solutions are permanent:

- a. Manager and/or Culinary Coordinator or designee will monitor that solutions implemented are in place.

G. Regulatory Insufficiency: 481-69.28(6)a Food Service. 481.69.28(231C) Food Service. 69.28(6) Programs engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and shall be licensed pursuant to Iowa Code chapter 137F. The Department will not require the program to be licensed as a food establishment if the following: a. All main meals and planned menu items must be prepared offsite and transferred to the program kitchen for service to tenants.

1. Elements Detailing the programs correction of the insufficiencies:

- a. Culinary Coordinator and/or designee completes daily cleaning schedule for hot cart that delivers food to the memory care area at mealtime. The hot cart will be cleaned after each meal, each day.

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

- a. Random audits will be completed for daily, weekly, and monthly by the manager and/ or designee.

3. Measures taken to ensure problem does not reoccur:

- a. New Culinary Coordinator has been hired. Culinary Coordinator and Culinary staff received re-training related to cleanliness of equipment and meal service items.

4. Program plans to monitor performance to ensure solutions are permanent.

- a. Manager and/or Culinary Coordinator or designee will monitor that solutions implemented are in place.

H. Regulatory Insufficiency: 481-69.34(1) Activities. 481-69.34(231C) Activities. 69.34(1)

The program shall provide appropriate activities for each tenant. Activities shall reflect individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities, and skills by providing opportunities for a variety of types and levels of involvement.

1. Elements Detailing the programs correction of the insufficiencies:

- a. Life Enrichment Coordinator is following scheduled activities per activity calendar, with activities of resident's interest in place. Alternate staff to assist in providing activities in memory care when Life Enrichment Coordinator is not present as scheduled on the Activity Calendar.

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

- a. Random audits completed daily, weekly, monthly as needed, as determined by the Manager or designee to ensure appropriate activities are occurring.

3. Measures taken to ensure problem does not reoccur:

- a. Life Enrichment Coordinator completing a Life Story for each new resident to get to know them and the types of activities they are interested in.
- 4. Program plans to monitor performance to ensure solutions are permanent.
 - a. Manager and/or Life Enrichment Coordinator or designee will monitor that solutions implemented are in place.