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
	S0117	A. BUILDING: _____ B. WING _____	C 12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY ACRES JOHN'S HARBOR MEMORY S	3520 GRAND AVE DES MOINES, IA 50312

(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. Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 16 Total census: 16 The following regulatory insufficiency was cited during the investigation of Complaint #106971-C.	A 000		
A 160	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 interview and record review the program failed to ensure appropriate cares and services were provided to 1 of 3 former tenants reviewed (Tenant C-1) Findings include: On 11/29/22 record review revealed Tenant C-1 was admitted to the program with diagnoses including Parkinson's disease and dementia. The service plan revealed Tenant C-1 requested staff administer medications. A review of Incident Reports revealed: - On 4/13/22 at 10:32 a.m. Tenant C-1 had	A 160	During the time of this incident, the program had lost a nurse in John's Harbor and was actively seeking to hire an additional nurse on that floor. Shortly following this incident, a new nurse was hired, which has enabled leadership to provide more direct training, guidance and direction to all staff as well as more closely monitoring of drug availability. This PRN Tylenol should have been reordered before running out. It has now been brought to staff's attention that all medication needs to be checked regularly and reordered from the pharmacy before running out. The staff that failed giving the PRN Tylenol should have taken this med out of stock meds and given it to the resident. Current staff have been educated on both of these scenarios and how to address them in the future. Future staff will be educated on both scenarios and how to address them in the future. This insufficiency was corrected on 2/7/2023.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0117	A. BUILDING: _____ B. WING _____	C 12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY ACRES JOHN'S HARBOR MEMORY S	3520 GRAND AVE DES MOINES, IA 50312

(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 160	Continued From page 1	A 160		

fallen.
- On 4/14/22 at 12:20 a.m. Tenant C-1 had come to her door covered in blood from a laceration to the back of her head. The blood had dried. She was sent to the ED (emergency department) and returned back to the program.
- On 4/14/22 at 12:35 p.m. Tenant C-1 had gotten out of her wheelchair and fallen to the floor resulting in complaints of pain to her elbow.
- On 4/17/22 at 3:00 a.m. Tenant C-1 was found on the floor in supine positron with complaints of pain in her right hip.
- On 4/17/22 at 9:00 a.m. Tenant C-1 was found on the floor.

Review of Nurses Notes revealed:
- On 4/17/22 at 12:47 p.m. Tenant C-1's daughter was called as the tenant needed 1:1 care to keep her from trying to pull herself out of bed to the floor. The program requested either family members stay with the tenant 1:1 or the family hire private care providers to do so. When the daughter arrived that day she was told the tenant needed to go the ED for uncontrollable leg pain. The PRN (as needed) APAP (acetaminophen), Lidocaine patches, the hot and cold compresses and the leg massages performed by the daughter were not helping to relieve Tenant C-1's pain. The daughter took her to have her leg pain treated. The ED notified the DON that they wouldn't treat her leg pain because she was a fall risk. They also stated the tenant did not meet the criteria for an MRI (no history of pain and the current pain is not life threatening) or CT scan (never had an injury to low back or leg). The DON responded to the ED that the program could not manage the tenant's pain with what had been ordered and she also could not stay safely at the program without 1:1 supervision. The ED stated the hospital would admit while awaiting a SNF (skilled nursing facility) placement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0117	A. BUILDING: _____ B. WING _____	C 12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY ACRES JOHN'S HARBOR MEMORY S	3520 GRAND AVE DES MOINES, IA 50312

(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 160	Continued From page 2	A 160		

- On 4/17/22 at 6:30 p.m. The tenant's daughter sent a text saying she was taking the tenant home as the ED would not do anything. The daughter brought the tenant back to the program at 7:44 p.m. along with a private duty home health aide.
- On 4/18/22 at 6:30 a.m. A call was received from the private duty home health aide stating the tenant had been awake all night screaming in pain. The aide suggested the tenant be taken to the ED.
- On 4/18/22 at 6:58 a.m. The RN spoke to Staff M who confirmed the APAP had run out that night and she was unable to give any at 3:00 a.m. but had helped the home health aide with warm and cold compresses as well as repositioning.
- On 4/20/22 at 12:22 p.m. Tenant admitted to hospital. 1:1 supervision continued in the hospital.
- On 5/5/22 at 9:37 p.m. Tenant remained in hospital. She needed to go to a skilled nursing facility before returning to the program.
- On 6/6/22 at 12:27 p.m. Tenant C-1 was discharged from the facility on 6/4/22 per family request.

Tenant C-1 had a physician's order dated 10/21/21 for 2 tablets of APAP 500 mg every 6 hours as needed for pain/fever. A progress note revealed the tenant's APAP had run out on the evening of 4/18/22 and staff were unable to administer the next as needed dose at 3:00 a.m. The progress notes noted the last dose of APAP was administered at 9:00 p.m.

Review of Tenant C-1's Medication Administration Record (MAR) for the month of April 2022 revealed Staff M noted she administered Tenant C-1's APAP at 5:25 a.m. on 4/18/22 with a pain level noted at 9 out of 10. The medication was noted as ineffective. The 9:00 p.m. dose noted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0117	A. BUILDING: _____ B. WING _____	C 12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY ACRES JOHN'S HARBOR MEMORY S	3520 GRAND AVE DES MOINES, IA 50312

(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 160	Continued From page 3 as administered on 4/18/22 in the progress notes had not been noted on the MAR as having been administered. On 11/30/22 at 11:59 interview with Staff M confirmed Tenant C-1 had run out of her PRN APAP. She gave Tenant C-1 her last dose around 9:00 p.m. Staff M stated the tenant was in pain but she didn't know what to do at the time because she was working the floor alone. She tried to keep Tenant C-1 as comfortable as possible. Staff M said the APAP should have been reordered 3 days prior to running out, but when she checked it had not been reordered. The tenant was sent to the hospital the next morning. When the DON (at that time) came in that morning she was not happy with Staff M and said the tenant should have been sent to the hospital sooner. Staff M confirmed she had not called the nurse that night regarding the APAP running out or the tenant's level of pain. On 11/30/22 at 12:30 p.m. the DON confirmed Tenant C-1's APAP noted in the progress notes as having been administered on 4/18/22 at 9:00 p.m. was not noted on the MAR as being given at that time. The DON could not say why Tenant C-1's APAP hadn't been reordered.	A 160		