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
	S0075	N	C 01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY ACRES CENTRAL AL	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 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: 33 Number of tenants with cognitive disorder: 0 Total census of Assisted Living Program: 33 The following regulatory insufficiency was cited during the investigation of Complaint #94950-C:	A 000	All service plans on all tenants were reviewed to be sure they matched assessments. The PCC software used to create assessments and service plans will now accurately pull assessment data to the service plan that it generates. The assessment portion of the software was not pulling the assessment information to the service plan. For example, if "frequent UTI's" or "edema" was documented in the assessment portion of the software, this was not triggering on the service plan. All service plans were reviewed and now have assessments correctly pulling information to the service plan. All service plans were reviewed to be sure that the assessment data is now pulling over to the service plan and are now accurately reflecting the assessment. AND Any time a tenant's statements and nursing assessment disagree, both will now be included on the service plan. Residents who do not agree with the assessment portion (example – nurse assessed as incontinent but resident feels they are not incontinent due to small number of accidents) will now be noted on the service plans to address both the resident statements/believes and the nurse assessment. AND Residents who do not agree with staff observations (Example – staff reporting anxiety but resident does not feel they are anxious) will now be noted on the service plans to address both the resident statements/believes and the staff statements. Service plans will include the tenant wishes for	3/3/21
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure service plans were based on identified needs and evaluations and updated as changes occurred for 3 of 4 current tenants (Tenants #1, #2, #4) and 1 of 6 former tenants (Tenant C4) reviewed. Findings follow: 1. Record review on 12/23/20 revealed Tenant #1 had a Progress Note dated 12/8/2020 in which the RN (Registered Nurse) documented Tenant #1 was having urinary incontinence at night. The tenant did not utilize incontinence products, but was willing to try them. Tenant #1 received physical therapy services and the RN contacted them for help with this issue. She was not experiencing day time incontinence. The RN noted on 12/18/20, physical therapy had set an alarm to wake Tenant #1 up once during	A 083		

	the night to use the bathroom. Tenant #1 had a Functional, Cognitive, Health Assessment dated 12/11/20 which identified she was incontinent of bowel and bladder and was at risk for or had frequent urinary tract infections. Her service plan, last revised 12/2/20, noted she was independent with toileting and needed no assistance from staff. However, it did not identify her incontinence or risk for urinary tract infections. 2. Tenant #2 had a progress note dated 9/18/20 indicating she was complaining of nausea and burning with urination. Tenant #2 stated she felt mixed up as well. The RN called the doctor who had no appointments available until the following week. Tenant #2 went to the emergency room and was subsequently admitted to the hospital. She remained in the hospital until 9/22/20 with a urinary tract infection (UTI). An Unusual Occurrence Report was completed on 11/7/20 after Staff A told the RN she had a difficult time rousing Tenant #2 on 11/6/20 and had called 911. Tenant #2 told the RN on 11/7/20 she recalled the event from the night before, but was pretty groggy from taking a pain pill. She was diagnosed with a UTI. She was also given an IV antibiotic in the emergency room prior to being sent home. Tenant #2's service plan, last revised 10/21/20, did not address her urinary tract infections or the feelings of being mixed up or groggy which might accompany the infections staff should be encouraged to watch for. 3. An Unusual Occurrence Report was completed for Tenant #4 on 6/24/20 due to an incident when she was felt anxious and had a racing pulse. Tenant #4's pulse ranged from a high of 140 beats per minute to a low of 98 beats per minute over a period of a few hours. The tenant decided to go to the emergency room and was transferred there by ambulance and admitted to the hospital. Tenant #4 returned from the hospital on 6/29/20 with a diagnosis of Covid-19 and Atrial Fibrillation (A-fib). On 10/16/20, an Unusual Occurrence Report was completed as Tenant #4 was reportedly feeling anxious with her pulse racing "just like last time." Staff called 911 and Tenant #4 was admitted to the hospital with A-fib. A nurse's note also mentioned she was dizzy. Tenant #8 returned to her apartment on 10/20/20.		interventions and/or nurse's suggestions for interventions decided with input from the tenant. FOLLOW UP Service plans will be reviewed quarterly in tenants with personal care or medication management and at least annually in other tenants. Service plans will be reviewed with any significant change in condition to be sure the information on the assessment is matching and pulling to the service plan accurately. These reviews will be completed by a program RN.	

	Tenant #4's Functional, Cognitive, Health Assessment dated 10/20/20 identified she experienced edema and shortness of breath. She was evaluated as at risk for or had, frequent UTIs. On 12/30/20 at 3:15 PM, Staff A stated Tenant #4 sometimes paced and walked in the hallways and said she was anxious. When this occurred, Staff A talked with Tenant #4 and checked her vitals. On 12/29/20 at 8:50 AM, Staff D stated Tenant #4 worried about her phone, clock and her family. She often repeated the same questions over and over. On 12/22/20 at 4:10 PM, Staff E reported Tenant #4 experienced anxiety-type behavior such as worrying, wanting to sit with staff and complaining of a headache ever since her hospitalizations with A-fib. Tenant #4's edema, shortness of breath, A-fib history and anxiety were not identified on her service plan, last updated 7/8/20. 4. Former tenant C4 was diagnosed with a UTI on 2/18/20. An Unusual Occurrence Report indicated the tenant reported to the RN she had a sore on her bottom on 2/21/20 that felt torn. The RN recommended Tenant C4 change her incontinence garments four times daily as she only changed them 1-2 times a day due to cost. The RN scheduled an appointment with her doctor for 2/25/20. Tenant C4 began feeling ill the night of 2/21/20 with burning when she urinated and went to the emergency room where she was prescribed an antibiotic. Tenant C4 saw her doctor on 2/25/20 and was referred for physical therapy, occupational therapy and skilled wound nursing for the open area on her bottom. The tenant was also ordered compression hose which staff were to assist her with putting on. The edema in Tenant C4's legs on 3/19/20 was noted to be +2. On 3/26/20, the edema in her lower extremities was down to +1 to +2 with her compression hose on. Tenant C4 had Functional, Cognitive Health Assessments dated 11/8/19, 11/22/19, 11/26/19, 1/22/20, 2/11/20, 2/18/20, 2/22/20, 2/25/20 and 2/27/20 which identified she was incontinent of bowel and bladder and had a history of diarrhea. These assessments also noted Tenant C4 had skin tears, chronic wounds and stasis ulcers on her legs due to			

	edema. The service plan, last revised 3/25/20, did not identify incontinence of bowel and bladder, nor did it address the edema or what staff should do when they encountered these chronic conditions.			