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
	S0368	A. BUILDING: _____ B. WING _____	C 01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT SIENA HILLS	455 SW ANKENY ROAD ANKENY, IA 50021

(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 population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 35 Number of tenants with cognitive impairment: 26 Total census: 61 The following regulatory insufficiencies were cited during the investigation of Complaints #116065-C, #116167-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia. No regulatory insufficiencies were cited during the investigation of Complaints #117059-C and Incidents #114095-I, #116643-I, and #113646-I.	A 000	See Attached POC 4/13/24	
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0368	A. BUILDING: _____ B. WING _____	C 01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT SIENA HILLS	455 SW ANKENY ROAD ANKENY, IA 50021

(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 285	Continued From page 1 Program failed to obtain medications timely and administer according to doctors orders. This pertained to 1 of 1 current tenants reviewed with a medication change (Tenant #1) and 1 of 3 discharged tenants reviewed (Tenant C1). Finding follows: 1. Record review on 12/20/23 revealed Tenant #1's Progress Notes dated 9/6/23, documented a new physician's order for potassium chloride. The Medication Administration Record for September 2023 noted staff administered the medications as of 9/21/23. When interviewed on 1/10/24 at 11:21 a.m. the Healthcare Coordinator stated she received the orders for the potassium and failed to send them to the pharmacy because the fax machine did not work. She confirmed it took almost two weeks to get the medication. 2. Record review on 12/20/23 revealed Tenant C1's Comprehensive Assessment and Service Plan dated 4/9/23, indicated he required staff to administer his medications. The Comprehensive Assessment and Service Plan dated 6/30/23 indicated a change of medication administration to independent with family filling med planner and to receive reminders from staff to take medications. No signature page acknowledging and agreeing to the changes could be located. Review of his Medication Administration Record (MAR) for June and July 2023 noted instructions for staff to assist the tenant with his medication planner and observe him take the medications. Further review of the MAR for July 2023 revealed as of 7/25/23 an "X" was documented instead of staff initials. The MAR for August through October	A 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0368	A. BUILDING: _____ B. WING _____	C 01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT SIENA HILLS	455 SW ANKENY ROAD ANKENY, IA 50021

(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 285	Continued From page 2 2023 continued to show an "X" documented daily. When interviewed on 1/10/24 the Registered Nurse reported Tenant C1's family notified her sometime in August several days of pre-packaged and dated daily medications were still in the cupboard in his apartment. She said the staff offered only reminders and failed to inform her Tenant C1 refused continually. She confirmed Tenant C1 failed to take his daily medications for an extended period of time based on the leftover medications observed. She stated she attempted to contact family to sign the 6/30/23 service plan and failed to obtain the required signatures.	A 285		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide two hours of dependent adult abuse training within six months of employment. This pertained to 2 of 4 staff reviewed (Staff B and Staff C). Findings follow: Chapter 235B.16 requires employees complete two hours of training relating to the identification and reporting of Dependent Adult Abuse within six months of initial employment and at least two hours of additional dependent adult abuse identification and reporting training every three years thereafter.	A 380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0368	A. BUILDING: _____ B. WING _____	C 01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT SIENA HILLS	455 SW ANKENY ROAD ANKENY, IA 50021

(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 380	Continued From page 3 Record review of staff files on 12/19/23 revealed the following: 1. Staff B was hired 9/10/21. No dependent adult abuse training completed within six months of employment could be located. 2. Staff C was hired 5/17/22. No dependent adult abuse training completed within six months of employment could be located. On 12/21/23 at 1:35 p.m. the Director confirmed these findings.	A 380		
A 370	481-69.26(3)a Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain signatures following updates to the service plan as required. This pertained to 1 of 1 discharged tenant with a change in medication administration (Tenant C1). Finding follows: Record review on 12/20/23 of tenant files revealed Tenant C1's Comprehensive	A 370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0368	A. BUILDING: _____ B. WING _____	C 01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT SIENA HILLS	455 SW ANKENY ROAD ANKENY, IA 50021

(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 370	Continued From page 4 Assessment and Service Plan dated 4/9/23, indicated he required staff to administer his medications. The Comprehensive Assessment and Service Plan dated 6/30/23, indicated a change of medication administration to independent with family filling med planner and to receive reminders from staff to take medications. No signature page acknowledging and agreeing to the changes could be located. Review of his Medication Administration Record (MAR) for June and July 2023 noted instructions for staff to assist the tenant with his medication planner and observe him take the medications. Further review of the MAR for July 2023 revealed as of 7/25/23 an "X" was documented instead of staff initials. The MAR for August through October 2023 continued to show an "X" documented daily. When interviewed on 1/10/24 the Registered Nurse reported Tenant C1's family notified her sometime in August several days of pre-packaged and dated daily medications were still in the cupboard in his apartment. She said the staff offered only reminders and failed to inform her Tenant C1 refused continually. She confirmed Tenant C1 failed to take his daily medications for an extended period of time based on the leftover medications observed. She stated she attempted to contact family to sign the 6/30/23 service plan and failed to obtain the required signatures.	A 370		
A 556	481-69.30(3)b Dementia-Specific Education for Personnel 69.30(3) Dementia-specific continuing education b. Direct-contact personnel employed by or	A 556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0368	A. BUILDING: _____ B. WING _____	C 01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT SIENA HILLS	455 SW ANKENY ROAD ANKENY, IA 50021

(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 556	Continued From page 5 contracting with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide annual dementia training. This pertained to 1 of 1 staff employed longer than one year (Staff A). Finding follows: Record review on 12/19/23 revealed Staff A's file documented a hire date of 10/26/21. No annual dementia training completed in 2022 could be located. On 12/21/23 at 1:35 p.m. the Director confirmed these findings.	A 556		

Siena Hills STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0368	DATE SURVEY COMPLETE 12/11/23-12/18/23

Tag#	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag#1	481-69.26(3) a Service Plan 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. A.) If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.	**Tag#3 A370**	**What initial correction was made?** DOW attempted to have the service plans signed multiple times. The family gave 30-day notice and moved out.	**How will we ensure and maintain compliance going forward?** DOW will chart all communications with family regarding service plan on PCC. All service plans will be signed and printed copies will be saved in a filing system.	**Implementation Date:** 04/13/2024 **Completion Date:** Ongoing **Responsible Party:** Director or Designee

Compliance Date:_04/13/2024_____

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.

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.

Siena Hills STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	**PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0368**	DATE SURVEY COMPLETE 12/11/23-12/18/23

Tag#	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag#1	481.67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training related to the identification and reporting of the dependent adult abuse as required by Iowa Code Section 235B.16.	**Tag#2 A380**	Staff still employed have been assigned the DAA training to complete.	All new hires will receive DAA training within 6 mos of hire. An audit of all employees will be conducted quarterly to ensure this is being completed.	**Implementation Date:** 04/13/2024 **Completion Date:** Ongoing **Responsible Party:** Director or Designee

Compliance Date:_04/13/2024_____

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.

Siena Hills STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0368	DATE SURVEY COMPLETE 12/11/23-12/18/23

Tag#	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag#1	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written policy, which shall include the following: F. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.	**Tag#1 A285**	**What initial correction was made?** On 01/10/24 all providers were called, and all medications were updated. On 7/24/2023 DOW updated MAR and staff regarding resident needing medication reminders.	**How will we ensure and maintain compliance going forward?** The community has changed pharmacy companies and integrated with pharmacy so all new orders would be confirmed. Staff have been educated on medication planners. Medication change form has been implemented with required family signatures. Community also changed IT providers to local to better serve when the community with technology issues..	**Implementation Date:** 04/13/2024 **Completion Date:** Ongoing **Responsible Party:** Director or Designee

Compliance Date:_04/13/2024_____

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

Siena Hills STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0368	DATE SURVEY COMPLETE 12/11/23-12/18/23

Tag#	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag#1	481-69.30(3)b Dementia-Specific Education for Personnel 69/30(3) Dementia-Specific continuing education b. Direct-contact personnel employed by or contracting agency with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific continuing education annually. Alison Bilka BSN, RN Scott Bergen ED	**Tag#4 A556**	**What initial correction was made?** Staff still employed were assigned continuing education that includes Dementia-specific training.	**How will we ensure and maintain compliance going forward?** All employees will receive Dementia Specific training quarterly and will participate in Relias education involving dementia both upon hire and each year the employee is employed with Edencrest.	**Implementation Date:** 04/13/2024 **Completion Date:** Ongoing **Responsible Party:** Director or Designee

Compliance Date:_04/13/2024_____

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.