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 08/27/2024

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: 42 Number of tenants with cognitive impairment: 24 Total census: 66 No regulatory insufficiencies were cited during the investigation into Complaint #123001-C. The following regulatory insufficiencies were cited during the investigation into Complaint #118680-C, Complaint #120107-C, Complaint #121124-C and Complaint #121808-C.	A 000	The Plan of Correction is attached	
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 cares and services were consistently provided in a timely manner regarding 3 of 9 tenants reviewed (Tenant #3, Tenant #9 and an unidentified tenant).	A 160		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 10/7/24

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A 160	Continued From page 1 Findings include: 1) Review of a device activity report for calls for assistance for the month of August for Tenant #9 revealed response times of 59 minutes on 8/14/24, 37 minutes on 8/5/24, 32 minutes on 8/15/24, 30 minutes on 8/20/24, 28 minutes on 8/3/24, 27 minutes on 8/2/24, 25 minutes on 8/16/24, 24 minutes on 8/19/24, 23 minutes on 8/19/24 and 16 minutes on 8/14/24. On 8/22/24 at 9:35 AM, Tenant #9 stated he utilized a wheelchair as he had many strokes and one side of his body did not work well. Tenant #9 also had seizures. He would call staff to assist him when he had seizures. Tenant #9 also required staff to help him off the toilet when he had a bowel movement as his legs might go numb. Tenant #9 believed about half the time it took staff more than 15 minutes to respond when he requested their assistance. 2) A review of a device activity report for calls for assistance for Tenant #3 for the month of August revealed the following response times: 36 minutes on 8/12/24 at 6:11 AM, 32 minutes on 8/13/24 at 6:47 AM, 32 minutes on 8/17/24 at 7:59 AM, 24 minutes on 8/8/24 at 6:09 AM, 23 minutes on 8/3/24 at 7:03 AM, 19 minutes on 8/22/24 at 6:39 AM, 18 minutes on 8/3/24 at 6:12 AM and 18 minutes on 8/7/24 at 5:59 AM. On 8/20/24 during an observation of the medication administration process, Tenant #3 asked Staff B if he delivered morning medication because she was supposed to get her medication before breakfast, or on an empty stomach, but often did not receive it at that time. Tenant #3 often pressed her pendant to have staff deliver her medication but they would not bring her	A 160		

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A 160	Continued From page 2 medication before she ate breakfast. When interviewed on 8/21/24 at 8:15 AM, Staff C stated Tenant #3 often went to breakfast at 6:30 AM or 7:00 AM and would page staff to get her medication. 3) During the investigation the family member (FM) of a tenant approached the monitor to report concerns with staffing levels at the program. They stated the staff did a very good job but were overworked. The FM reported their loved one recently fell in their apartment, hit their head, and had blood on their face. The FM went to try and find a staff person to help. They knew the main staff was likely in another tenant's apartment but was unable to find her. The FM was unable to locate any other staff to assist. When unable to find any help for over 5 minutes, the FM called emergency services for assistance. 4) On 8/20/24 at 3:15 PM, Staff A reported staff were to respond to tenants within 5 minutes when they push a pendant for assistance. On 8/21/24 at 8:15 AM, Staff B stated she is able to respond to most pendants within 5 minutes. On 8/22/24 at 11:03 AM the Regional Director of Clinical reported the expectation was staff would respond to tenants' pendant's calls within 15 minutes.	A 160		
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:	A 285		

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A 285	Continued From page 3 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 program failed to ensure medications were administered as ordered to 1 of 3 discharged tenants reviewed (Tenant C3). Findings follow: Record of progress notes on 8/20/24 revealed Tenant C3 moved to the program on 5/7/24. The program's Registered Nurse (RN) completed a pre-admission assessment on 5/7/24 and noted Tenant C3 required assistance with all activities of daily living, ambulation and transfers. Tenant C3 carried diagnoses of osteoporosis, osteoarthritis and spinal stenosis. She would call out in pain with movement. She was incontinent of bladder and bowel. Tenant C3 received hospice services. She scored a 6 on the Global Deterioration Scale indicating severe cognitive decline. Tenant C3 experienced a fall on 5/11/24. She complained of back pain and head pain. Hospice came to assist Tenant C3 following the fall. On 5/16/24 at 4:30 AM, Tenant C3 was found on the floor during a visual check. Two staff attempted to assist Tenant C3 back to bed but she refused. The RN called emergency services for assistance and they helped Tenant C3 back to bed. Tenant C3's family and hospice were notified.	A 285		

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A 285	Continued From page 4	A 285		

The program received a fax on 5/16/24 from Tenant C3's primary care provider. They received orders to discontinue hydrocodone and xanax. The program was to start administering morphine sulfate three times daily (and as needed every 4 hours) and ativan twice daily (and every 4 hours as needed) due to increased pain and difficulty taking medication.

According to a progress note, on 5/17/24 at 6:46 PM, the on-call nurse received a call from a resident assistant (RA) informing her the tenant's family was in the building and advised the RA of a meeting held the previous day with one of the program's RNs and hospice. It was decided at that time hydrocodone and xanax were to be discontinued and replaced with ativan and morphine. The RA was confused because there were active orders for hydrocodone, xanax, ativan and morphine on the MAR. The on-call nurse put the hydrocodone and xanax on hold and notified the Director of Wellness as there were no notes or orders present to verify the information.

A review of the May Medication Administration Record (MAR) for Tenant C3 revealed she was administered xanax at 8:00 PM on 5/16/24 and at 8:00 AM on 5/17/24, after the medication was discontinued. Tenant C3 was administered hydrocodone on 5/16/24 at 2:00 PM and 8:00 PM and on 5/17/24 at 8:00 AM and at 2:00 PM. Program staff administered the first doses of ativan and morphine on 5/16/24 at 8:00 PM.

Tenant C3 moved to a hospice house on 5/21/24.

During an interview on 8/21/24 at 4:50 PM, Tenant C3's hospice nurse reported Tenant C3 was unable to swallow her scheduled

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A 285	Continued From page 5 hydrocodone and experiencing a lot of pain. There was a meeting with Tenant C3's family and the RN on 5/16/24 in which they discussed Tenant C3's decline and how they wanted to keep her comfortable. There was agreement they would discontinue the hydrocodone and get orders for liquid morphine and liquid ativan. The RN reported when the medication came in, a hospice nurse would need to fill the syringes. The hospice nurse called and got the orders from the doctor as well as the orders faxed to the pharmacy. It was agreed the program would call hospice when the medication arrived so they could fill the syringes with the medication. Program staff did call hospice when the pharmacy delivered the medication and the hospice on-call nurse did go to the program and fill the syringes. Tenant C3 should not have received the double doses of medication. The RN knew the oral pills had been discontinued and should have communicated with staff not to administer the pills when the liquid medication arrived. The Regional Director of Clinical confirmed these findings on 8/26/24 at 11:03 AM.	A 285		
A 395	481-69.26(4)a 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 This REQUIREMENT is not met as evidenced by:	A 395		

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A 395	Continued From page 6	A 395		

Based on observation, interview and record review, the program failed to ensure the service plan identified the needs on the service plan of 1 of 6 tenants reviewed (Tenant #2). Findings follow:

During a tour of the building on 8/20/24 at 2:30 PM with the Executive Director, a walk through was done of Tenant #2's apartment. Tenant #2 was laying in his bed with a brown substance visible on his sheets. There was a strong odor which the Executive Director identified as urine. The Executive Director reported Tenant #2's power of attorney arranged for a professional cleaning of the apartment about two months ago due to issues with odor and poor cleaning. Tenant #2 got a new mattress at that time as the old mattress was soiled.

Tenant #2 met with his primary care provider (PCP) on 7/26/24 for a routine visit. The PCP documented hygiene was an issue again for Tenant #2 and his room was very unkempt which was a chronic problem.

On 8/20/24 at 3:15 PM, Staff A reported staff were to prompt Tenant #2 to go to the bathroom hourly, but his wife would say no, he didn't need to use the bathroom as he had just gone. Tenant #2 and his wife wouldn't let the housekeeper clean their apartment. They would let staff wash their laundry, which was usually soiled.

Tenant #2 had a service plan dated 6/14/24. The service plan identified Tenant #2 was incontinent of bladder and used incontinence products. The plan noted Tenant #2 preferred to have a neat and clean apartment.

The service plan did not identify Tenant #2 was

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A 395	Continued From page 7 incontinent of bowel or interventions staff could use if he would not use the toilet. The service plan did not address Tenant #2's housekeeping issues. The Director of Wellness confirmed this finding on 8/22/24 at 3:00 PM.	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: Edencrest at Siena Hills CLIA 16D2136803	DATE SURVEY COMPLETED: August 27, 2024

ID PREFIX 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	**Regulation and Reg Number A160 – 481-67.3(2)** Tenant Rights Based on interviews and record review the program failed to ensure tenants received adequate and appropriate care. A regulatory insufficiency was cited.	Tag # 118680-C	What initial correction was made? For Tenant #9, Tenant #3, and the unidentified tenant, individual staff education was completed on 8/27/24. An all-staff Inservice was completed on 8/29/2024 to review call light and tenant rights policy and procedures.	How will we ensure and maintain compliance going forward? Scheduler will pull call light reports daily for 30 days or until substantial compliance is achieved. Scheduler or designee will continue to monitor call lights regularly and as needed going forward as part of our quality assurance process. Current staff members will receive additional education and training as needed and new staff members will receive training on the Call Light Policy and Procedures prior to completion of their orientation/training.	Implementation Date: 08/27/2024 Completion Date: Ongoing Responsible Party: Director and/or Designee
Tag #2	**Regulation and Reg Number A285 – 481.67.5** Medications Based on interview and record review, the program failed to ensure medications were administered as prescribed by the tenant's physician, advanced registered nurse practitioner, or physician assistant.	Tag # 118680-C	What initial correction was made? Tenant #3 has passed away. The RN processing those medications at the time no longer works for the program and was immediately relieved of her duties when the program became aware. Training provided to the program's RN director of wellness on processing orders timely. The program now has daily cooperation	How will we ensure and maintain compliance going forward? Medication process training will be completed with each new RN who starts at our program.	Implementation Date: 08/27/2024 Completion Date: Ongoing Responsible Party: Director and/or Designee

			on new orders for residents receiving hospice services.		
Tag #3	**Regulation and Reg Number** **A 395 – 481-69.26(4)a** Service Plans Based on observation, interview and record review, the program failed to ensure the service plan identified the needs on the services plan of 1 of 6 tenants reviewed (Tenant #2).	Tag # 121808-C	What initial correction was made? Completed mitigated risk with Tenant #2 regarding the cleanliness of the apartment. Home Health services will be starting 10/7/2024. A change of condition assessment was completed, and the service plan was updated. An audit was completed on residents who may have refused cares and their individual service plans were updated.	How will we ensure and maintain compliance going forward? Director and/or Designee and Nurse(s) will review comprehensive assessments and service plans weekly, monthly, as needed as determined by the Director or designee. Signatures will be obtained on service plans upon admission or attempts to obtain signatures will be documented.	Implementation Date: 08/27/2024 Completion Date: Ongoing Responsible Party: Director and/or Designee

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.