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
	S0369	A. BUILDING: _____ B. WING _____	C 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT BEAVERDALE	3410 BEAVERDALE AVENUE DES MOINES, IA 50310

(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: 47 Number of tenants with cognitive impairment: 21 Total census: 68 No regulatory insufficiencies were cited as a result of the investigation of Incident 119799-I. The following regulatory insufficiencies were cited during the investigation of Complaint #123900-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000	The POC is attached	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the Program failed to follow policy and consistently ensure medications were labeled appropriately. This affected 1 of 2 tenants who received insulin and lived on the 700 hallway (Tenant #1). Finding follows: Observations on 10/15/24 at 12:25 p.m. revealed Staff A administered medications to Tenant #1. Tenant #1's medication cabinet contained two Lantus Solostar insulin pens. The pens were	A 150		

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A 150	Continued From page 1 labeled with Tenant #1's name but nothing else. An additional sticker used to document when staff opened and utilized the pen had no date/documentation. When interviewed on 10/17/24 at 1:20 p.m. Staff B confirmed staff had failed to date the insulin pen when it was used and acknowledged documenting the date the staff used the pen would ensure staff did not administer expired insulin to Tenant #1. Record review on 10/17/24 revealed the Program's medication policy (no date) directed each tenant's medication shall be stored in original received container. Medications shall be labeled and maintained in compliance with label instructions and state and federal laws. During the exit on 10/17/24 at 3:00 p.m. the administrative staff acknowledged the Program failed to follow the medication policy.	A 150		
A 275	481-67.5(2)f(2) 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: (2) Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications. This REQUIREMENT is not met as evidenced by:	A 275		

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A 275	Continued From page 2 Based on observations, interview and record review the Program failed to follow policy and consistently ensure medications were locked and secured. This affected 1 of 2 tenants who received insulin and lived on the 700 hallway (Tenant #1). Finding follows: Observations on 10/15/24 at 12:25 p.m. revealed Staff A administered medications to Tenant #1. Tenant #1's medication cabinet contained two Lantus Solostar insulin pens. The pens were labeled with the Tenant #1's name but nothing else. An additional sticker used to document when staff opened and utilized the pen had no date. When interviewed Staff A, who administered the medications, said Tenant #1's additional pens were stored in the refrigerator in the common area kitchen. Observations on 10/17/24 at 1:20 p.m. revealed the Program had removed the pens from the common refrigerator. When interviewed on 10/17/24 at 1:20 p.m. Staff B said the nurse had gotten a refrigerator to be placed in the locked laundry room to used to store tenants' extra insulin pens. When questioned Staff B said Tenant #1's insulin pens had been stored in the common refrigerator until that day. She said the nurse must have moved them. Record review on 10/17/24 revealed the Program's medication policy (no date) documented medications shall be kept in a locked location that is not accessible to persons other than employees responsible for the supervision of such medications. Staff members administering medications shall have a key to access medications.	A 275		

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A 275	Continued From page 3 During the exit on 10/17/24 at 3:00 p.m. the administrative staff acknowledged the Program failed to lock medications as required per the medication policy.	A 275		
A 390	481-69.26(3)e 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. e. The service plan shall be reviewed, updated if necessary, and signed and dated by all parties at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure tenant service plans were signed and dated. This pertained to 1 of 2 sample tenants (Tenant#1) who resided in the 700 hallway. Finding follows: Record review on 10/15/24 revealed Tenant #1's annual service plan review was completed on 1/25/24. Further review revealed no signatures or dates. During the exit on 10/17/24 at 3:00 p.m. the administrative staff acknowledged the Program failed to obtain signatures as required.	A 390		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be	A 635		

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A 635	Continued From page 4 connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on observation and interview the Program failed to consistently ensure an operating door alarm on each exit door. This potentially affected 21 of 21 tenants who scored four on the Global Deterioration Scale (GDS). Finding follows: Observations on 10/17/24 at 1:45 p.m. revealed the patio door in the 700 hallway did not function properly when opened. Observations on 10/17/24 at 2:30 p.m. revealed the West door outside the activity room had no operating alarm. When interviewed on 10/17/24 at 2:30 p.m. Quality Assurance Nurse said the Program would address the issue immediately to ensure the doors had an operating alarm.	A 635		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: Edencrest at Beaverdale	DATE SURVEY COMPLETED: November 11, 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** The program shall follow the policies and procedures established by the program Each program shall follow its own written medication policy, which shall include when medications are administered traditionally by the program	**Tag # A-150** **Tag #A-275**	**What initial correction was made?** -Placed plastic bags with prescription of medication label in locked cabinet in residents' room -Obtain additional labels and storage bags -Educated Beaverdale staff on the insulin storage protocol -Placed refrigerator in memory care laundry room for insulin	**How will we ensure and maintain compliance going forward?** -Create an Edencrest wide training for insulin storage -Create and maintain a sign out sheet in Assisted Living by the refrigerator in the workroom to check in new insulin pens when they arrive from the pharmacy. -Create and maintain a sign-out sheet in Memory Care -by the refrigerator in the workroom to check in new insulin pens when they arrive from the pharmacy. -Checking weekly to ensure that insulin pens are dated when the pen is opened and with expiration date and kept in labeled plastic bags in the resident's room in their locked cabinet	**Implementation Date**: Immediately **Completion Date:** -Ongoing **Responsible Party:** -Director and/or Designee Director of Nursing
Tag #2	**Regulation and Reg Number** 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	**Tag # A-390**	**What initial correction was made?** -Sent ISP out for immediate signature and uploaded it into the resident's chart -	**How will we ensure and maintain compliance going forward?** -As soon as Addendum B and ISP are printed and signed the signed copy will be uploaded into resident's chart Spelling error -Look at all ISPs from 10/17/24 to ensure signatures are present -Look at historical QA reports for unsigned ISPs and obtain signature	**Implementation Date** Immediately **Completion Date:** - Weekly for 4 weeks -Monthly for 12 months -Ongoing **Responsible Party:** Director and/or Designee

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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.

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