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
	S0372	A. BUILDING: _____ B. WING _____	C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT THE LEGACY	**2901 CEDAR STREET NORWALK, IA 50211**

(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: 19 Number of tenants with cognitive impairment: 9 Total census: 28 No regulatory insufficiencies were cited during the investigation of Incident #116476-I. The following regulatory insufficiencies were cited during the investigation of Complaint #117491-C.	A 000		
A 135	481-67.2(1)f Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: f. A copy of the completed incident report shall be kept on file on the program's premises for a minimum of three years. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to retain incident reports on premises for at least three years. This pertained to 2 of 2 tenants reviewed (Tenants #1 and #2). Findings follow:	A 135	The Plan of Correction is attached	

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

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
	S0372	A. BUILDING: _____ B. WING _____	C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT THE LEGACY	**2901 CEDAR STREET NORWALK, IA 50211**

(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 135	Continued From page 1 Upon entrance on 6/11/24 incident reports were requested. The Program provided incident reports (IR) from 1/1/24- 6/11/24. On 6/12/24, when asked again for incident reports from 11/1/23-12/31/23, the Program's consultant explained the IRs could not be located. She explained the Program had a change in ownership as of 1/1/24 and the former group could not provide the requested information. On 6/17/24 at 3:45 p.m. the Program confirmed they could not locate the incident reports for Tenants #1 and #2.	A 135		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure an operating door alarm on each exit door. This potentially pertained to 9 of 9 tenants who scored four or more on the Global Deterioration Scale (GDS). Finding follows: Observation on 6/11/24 at 1:11 p.m. revealed a dumbbell held open the West door outside the activity office. Further observations revealed a tenant in the garden outside the door. When the surveyor brought the dumbbell to staff's attention, staff removed the dumbbell from the door and informed the Director. At 1:12 p.m. the Director confirmed staff/tenants should not prop the door	A 635		

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
	S0372	A. BUILDING: _____ B. WING _____	C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT THE LEGACY	**2901 CEDAR STREET NORWALK, IA 50211**

(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 635	Continued From page 2 open. On 6/17/24 at 3:45 p.m. the administrative team confirmed staff/tenants had been notified to refrain from propping the door open for safety reasons.	A 635		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: Edencrest at the Legacy/ 16D2147135	DATE SURVEY COMPLETED: August 23, 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** 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: f. A copy of the completed incident report shall be kept on file on the program's premises for a minimum of three years. Complaint #117491-C.	Tag # A-65	What initial correction was made? 1. Formally reached out to Jaybird Senior Living for Incident Report. They are unable to obtain from their Yardi EHR.	How will we ensure and maintain compliance going forward? 2. Formally reached out to Jaybird Senior Living for Incident Report. They are unable to obtain from their Yardi EHR. 3. Every IR will be input into PCC and kept on file. These will be monitored monthly by Ed and designee. 4. Compliance date: 09/09/2024	Implementation Date:09/09/2024 Completion Date: Ongoing Responsible Party: Director and/or Designee
Tag #2	**Regulation and Reg Number** 481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.	Tag # A-135	What initial correction was made? 1. Installed an Arial alarm system device to the exit door.	How will we ensure and maintain compliance going forward? 2. Completed an instant in-service with all employees to educate. 3. The Maintenance Director tests the alarm system on all exit doors weekly. Compliance Date: 09/09/2024	Implementation Date: 09/09/2024 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.