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
	S0414	A. BUILDING: _____ B. WING _____	C 07/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWATER AL - BROOKSIDE	9225 CASCADE AVENUE WEST DES MOINES, IA 50266

(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. General Population Program Number of tenants without cognitive disorder: 27 Number of tenants with cognitive disorder: 5 Total Population of Program at time of on-site: 27 TOTAL census of Assisted Living Program: 32 No regulatory insufficiencies were cited during the investigation of Incident #98418-I, Complaint #96360-C, or the onsite infection control survey. The following regulatory insufficiencies were cited during the investigation of Complaint #98415-C.	A 000	A 000 Correction Date: 7/19/2021 PLAN OF CORRECTION This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alledged or conclusions set forth in the statement of deficiency. The plan of correction is prepared and/or executed solely because it is required by the provisisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirement of participation, or that corrective action was necessary.	
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: Based on interview and record review the Program failed to develop individualized service plans based on tenants' identified needs and preferences for assistance. This pertained to 1 of 1 tenants with a history of refusals for assistance (Tenant #1). Findings follow: Record review on 7-12-21 of Tenant #1's	A 395	In continuing compliance with A 395 Regulation 481-69.26 (4)a Service Plans, Edgewater immediately corrected the deficiency. 1. To correct the deficiency, Tenant #1 service plan was updated to reflect current care needs and individualized preferences. In addition all other service plans were reviewed for accuracy and thoroughness. 2. To ensure that the problem does not recure, Edgewater Nursing will ensure that all tenant assessments will be completed quarterly or if a significant change triggers a review, and any necessary service plans changes will be updated immediately and staff members will be educated on those changes. The program director will provide monthly monitoring to ensure timeliness of assessments and any service plan changes. 3. As part of Edgewater's on-going commitment to quality assurance, assessments will be completed quarterly or if a significant change of condition occurs, and service plans will be reflect current needs and individual preferences. The program director will monitor monthly to ensure assessments are completed on time and any changes to service plans will be done immediately.	

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

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 395	Continued From page 1 Progress Notes revealed the following: a. On 6-29-21 Tenant #1 continued to resident help with monitoring his blood sugars and insulin and stated he wanted to be left alone. He continued to refuse assistance for showers and medication management. His doctor wrote an order for Tenant #1 to manage his own blood sugars and insulin. b. On 6-29-21 Tenant #1 refused to administer his insulin or eat lunch with his blood sugar at 305. c. On 6-30-21 Tenant #1 refused several requests for bathing assistance and noted he asked staff to leave his medications and removed two medications he wished to no longer take. He continued to refuse to self administer insulin as ordered. d. On 7-1-21 Tenant #1 informed staff to leave his medications on the counter to take later. e. On 7-1-21 the Registered Nurse (RN) informed Tenant #1 of medication change and asked him when he would like a shower. He closed his eyes said he wanted to rest. Review of Tenant #1's Global Deterioration Scale dated 6-22-21 revealed no cognitive impairment. Review of the Service Plan dated 6-22-21 failed to include on-going refusals to shower and take his medications and insulin as ordered by his physician. On 7-12-21 at 2:05 p.m. the Director confirmed these findings.	A 395		