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
	S0450	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT THE TUSCANY MC	1600 8TH STREET SE ALTOONA, IA 50009

(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 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: 20 Number of tenants with cognitive disorder: 2 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 15 TOTAL census of Assisted Living Program for People with Dementia: 37 The following regulatory insufficiencies were cited during the investigation of 103639-C, 103638-C, 105325-C.	A 000		
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 provide adequate and appropriate care, treatment, and services to 1 of 3 tenants reviewed with a cognitive impairment	A 160		

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

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A 160	Continued From page 1	A 160		

(Tenant #1) and potentially affected all 15 tenants in the memory care unit. Findings follow:

1. Observations on 7-5-22 around 3:00 p.m. revealed a person sitting in a chair facing the television, her head laid back and her eyes closed. After approximately 15 minutes the surveyor approached and asked if she was a visitor. She sat up and said "What?" and the question was repeated. She stated she worked for a temp agency to fill in today. When asked about her job duties she again required the question to be repeated. She stood up and responded "Take care of the folks in here". The surveyor asked if this was the first time working here and she said "OK" then walked away. Another agency staff sat at a table and observed two tenants watching tv. A Program staff assisted Tenant #1 with cares.

Interviews with family members of three tenants expressed their concerns about temp staff during the past few months. They stated they would arrive and staff would be on their phones or watching tv. They would find the tenants soiled and at times found dried feces on the briefs and/or clothing. They reported their concerns to the manager and the nurse and stated it did not improve much due to on-going change in the temp staff.

2. When interviewed on 7-7-22 Staff C stated she arrived to administer medication and observed Tenant #1 laying in bed with his head flat and his legs hung over the side of the bed as Staff A attempted to feed him toast. Staff A reported he wasn't eating and Staff C told her to stop trying to feed him because he could choke. Staff C left the room to report this to the nurse and then called Staff B for assistance. She told Staff A to go cover

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A 160	Continued From page 2	A 160		

another hall. Staff C placed her hands under his bottom and the bedding was soaked with urine. She said the sheets, two blankets, and a comforter were soaked through as well and required a complete bed change. Staff C acknowledged concerns with Staff A and said at times Staff A would report tenants refused to comply with cares and leave it for another staff to complete. Staff A confirmed she found tenants soiled when she arrived to administer medications. The agency staff assigned were sitting around and stated the tenant refused assistance.

When interviewed on 7-6-22 at 10:34 a.m. Staff B reported Staff C called her for assistance for Tenant #1 hanging off his bed and they discovered he was soaked with urine. The bedding was soaked with urine as well. Staff B stated Staff A told her the overnight staff didn't do cares because he was combative. Staff B asked her why she didn't clean him up and Staff A walked away. Staff B said she observed Staff A outside in the courtyard with no tenants and at times on her phone. She confirmed you can not observe any tenants when outside and only one staff would be assigned to each hall.

When interviewed on 7-6-22 at 11:06 a.m. Staff A confirmed she failed to provide personal cares to a tenant after the overnight agency staff reported to her the tenant refused to allow him to change him. She stated she visually checked in on him and he was asleep so she left to get the "easy ones" up first and returned to him around 9:00 a.m.

When interviewed on 7-6-22 at 4:27 p.m. Staff D expressed concerns about some of the temporary staff. She observed tenants soiled when she

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A 160	Continued From page 3 arrived in the memory care to administer medications. She stated they would say they had just checked on them and she instructed them to check them again. She reported some of the temp staff would put tenants to bed around 7:30 p.m. and she asked them why and they stated the tenant wanted to. When interviewed on 7-6-22 at 10:21 a.m. Staff E reported at times she found tenants soiled when she arrived at 6:00 a.m. She stated it usually occurred when the overnight staff came from an agency. On 7-6-22 at 11:30 a.m. the Manager confirmed ongoing issues with agency staff. She stated staff and families expressed concerns of them sitting around and not providing cares as required.	A 160		
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 observation and interview the Program failed to have an alarm on the exit door to the courtyard in the memory care unit. Findings follow: Observations on 7/5/22 and 7/6/22 revealed a fenced in courtyard between two wings of the dementia unit. Both wings had an exit door in the dining room that led into the courtyard. Staff walked between the two wings through these	A 635		

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A 635	Continued From page 4 doors several times during the on-site visit. When interviewed on 7/7/22 at 8:45 a.m. the Manager reported the doors leading to the courtyard were not locked because the gates in the courtyard were. When interviewed at 12:53 p.m. the Manager stated the exit doors into the courtyard could be locked with a key. She further confirmed staff walked back and forth through the doors.	A 635		