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 09/19/2024

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 population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 18 Number of tenants with cognitive impairment: 19 Total census: 37 The following regulatory insufficiencies were cited during the investigation of Incident #118262-I and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000	The Plan of Correction 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 interview and record review, program staff failed to follow procedures for completing visual checks on 1 of 1 discharged tenants reviewed (Tenant C1). Findings include: Record review on 9/18/24 revealed an incident report for Tenant C1 dated 1/15/24 at 11:30 PM. Tenant C1 pressed her pendant and Staff A responded. Tenant C1 was lying on her bedroom floor. Staff A assisted Tenant C1 off the floor. The hand-written incident report identified Tenant C1 was guided up from the floor with the assist of one person. Tenant C1 had a bruise and knot on	A 150		

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A 150	Continued From page 1	A 150		

her head.

Tenant C1 had a service plan dated 12/1/23. The service plan identified staff were to provide visual/safety checks on Tenant C1 every 1 hour daily.

A point of care audit report for Tenant C1 listed the times staff documented safety checks for Tenant C1 on 1/15/24. No one documented they checked on Tenant C1 after 9:56 PM on 1/15/24. Staff A did not document checking on Tenant C1.

A progress note dated 1/17/24 identified Tenant C1 was admitted to the hospital on 1/17/24 with a diagnosis of a fracture of the left greater trochanter. She underwent surgery to treat the fracture. Tenant C1 did not return to the program. She required a higher level of care after leaving the hospital.

On 9/17/24 at 4:15 PM, Staff A reported she checked on Tenant C1 around 10:00 PM - 10:15 PM with Staff B. Tenant C1 was sitting in her recliner watching television. She seemed fine. Tenant C1 then pressed her pendant for assistance. Tenant C1 informed Staff A she fell when she was attempting to go to the bathroom on her own. Tenant C1 reported some pain.

On 9/18/24 at 12:12 PM, Staff B reported she did not do rounds with Staff A. Staff A was assigned to the hallway in which Tenant C1 resided, so doing the supervisory checks was Staff A's responsibility. Staff members did not check on tenants with other employees, they did this alone. Staff B did respond to Tenant C1's apartment after the fall. Tenant C1 reported pain in the hip area. Staff B recalled Tenant C1 was the type of person who needed assistance to go to the

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A 150	Continued From page 2 bathroom due to poor balance, but would not wait for help. It was not unusual for her to get up on her own. The program had a procedure on completing visual checks. Staff were to document visual checks at the scheduled time. Visual checks were meant to be completed as close to the scheduled time as possible. On 9/18/24 at 8:50 AM, the Health Care Coordinator confirmed there were no supervision checks for Tenant C1 after 9:56 PM on 1/15/24 but they should have been completed hourly. Tenant C1 was not checked on every hour as directed in her service plan.	A 150		
A 410	481-67.19(3)b Record Checks 67.19(3)b Conducting a background check. The program may access the single contact repository (SING) to perform the required background check. If the SING is used, the program shall submit the person's maiden name, if applicable, with the background check request. If SING is not used, the program must obtain a criminal history check from the department of public safety and a check of the child and dependent adult abuse registries from the department of human services. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to complete background checks prior to hire for 1 of 7 employees reviewed (the Culinary Coordinator). Findings follow:	A 410		

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A 410	Continued From page 3 Record review of the staff list on 9/17/24 revealed the Culinary Coordinator was hired on 1/31/24. The program did not complete the required background checks until 2/1/24. During an interview with the Executive Director and Culinary Coordinator on 9/17/24 at 12:40 PM, both confirmed the Culinary Coordinator actually began employment in December of 2023. On 9/18/24 at 4:40 PM, the Executive Director confirmed no background check could be found corresponding to the Culinary Coordinator's actual start date in December of 2023. The Executive Director stated the former Executive Director had not run the background check and asked an employee at another program location to run the background check for him. However, a copy of the background check could no longer be obtained due to a change in management companies. Upon discovering the missing background check, the current Executive Director requested a background check for the Culinary Coordinator which was completed on 2/1/24. The Executive Director confirmed these findings on 9/19/24 at 11:40 AM.	A 410		

Edencrest at Tuscany STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0450 CLIA 16D2211822	DATE SURVEY COMPLETE 09/17-09/19/2024

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#l	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program.	**Tag#l A150**	**What initial correction was made?** Tenant C1 date of 1/15/24 no longer resides at Tuscany.	**How will we ensure and maintain compliance going forward?** On 9/26/24 RN Emily Moses provided on-site training regarding policy for pendant response times and visual checks during all staff meeting. To maintain compliance weekly (x4 weeks) and monthly reports thereafter being audited for compliance of visual checks. .	**Implementation Date: 9/26/24** **Completion Date:** Ongoing **Responsible Party:** Director or Designee

Compliance Date: 9/26/2024 & Ongoing

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.

Tuscany STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0451 CLIA 16D2211822	DATE SURVEY COMPLETE

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#2	481-67.19(3)b Record Checks 67.19(3)b Conducting a background check. The program may access the single contact repository (SING) to perform the required background check. If the SING is used, the program shall submit the person's maiden name, if applicable, with the background check request. If SING is not used, the program must obtain a criminal history check from the department of public safety and a check of the child and dependent adult abuse registries from the department of human services. This	**Tag#2 A410**	**What initial correction was made?** A background check was initiated and completed immediately after the director became aware of the issue. Successful background check returned on employee in question.	**How will we ensure and maintain compliance going forward?** A third party company is now doing background checks to ensure all background checks are completed prior to hire.	**Implementation Date: 1/1/2024** **Completion Date:** Ongoing **Responsible Party:** Director or Designee

Compliance Date: Effective 01/01/2024 & ongoing

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