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
	S0056	A. BUILDING: _____ B. WING _____	C 11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES ASSISTED LIVING	1499 OFFICE PARK RD WEST DES MOINES, IA 50265

(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. Number of tenants without cognitive disorder: 21 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 21 The following regulatory insufficiencies were cited during the Investigation of Incident #100877-I and the recertification visit conducted to determine compliance with certification of an Assisted Living Program. No regulatory insufficiences were cited during the onsite infection control survey.	A 000		
A 225	481-67.4(5) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(5) When a tenant attempts suicide, regardless of injury. This REQUIREMENT is not met as evidenced by:	A 225	Staff education related to suicide awareness and incident Reporting for major incidents	3-7-22
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 395		

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

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A 395	Continued From page 1 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 an individualized service plan that identified needs and preferences for assistance for 1 of 3 tenants reviewed (Tenant #1). Findings follow: Record review of Tenant #1's Progress Notes revealed the following: - On 5-6-21 Tenant #1's sister called the Program to report Tenant #1 had been drinking. Staff reported Tenant #1 admitted she had been drinking due to stress. - On 5-7-21 Tenant #1's Power of Attorney (POA) requested she abstain from alcohol consumption due to a history of abuse and health concerns. Orders from the Nurse Practitioner recommended one ounce of liquor per day for Tenant #1. Tenant #1 stated she preferred to ~~(Not to~~ participate in happy hour and would abstain from alcohol. - On 6-10-21 the Registered Nurse (RN) spoke with Tenant #1 about her recent falls and during the conversation she admitted to taking whisky from her father's home and willingly surrendered the bottle. - On 6-14-21 during a family meeting Tenant #1 agreed to surrender the keys to the vehicle her father allowed her to drive due to concerns of ongoing alcohol concerns and history of dependence. No updated service plan to reflect Tenant #1's alcohol dependence and interventions could be	A 395	Service plan updated to unclear managed risk Service plan updated to unclear suicidal ideations	10.1.21 11.11.21 3.7.22

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A 395	Continued From page 2 located. On 11-22-21 at 4:09 p.m. the RN confirmed these findings. • NURSE REVIEW. (DON) * In the future the RN will be responible for reviewing and updating tenats service plan or significant change of condition with each Quaterly review approximately every 90 days. effective date 3.7.22 - or as needed as situations arise. — MBRN	A 395	Please review attached Servic Plans dated 10.1.21 11.11.21 3.7.22 Thank you. MBRN	