STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165618	A. BUILDING _____ B. WING _____	C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 3/3/21 The Iowa Department of Inspection and Appeals (DIA) in accordance with the Medicare Conditions of Participation set forth in 42 CFR 483, Subpart B-C conducted this investigation. The facility was found to be NOT IN COMPLIANCE. Total residents: 27 Onsite dates: 02/18/21 - 02/25/21 Complaint and Facility Reported Incident #'s reviewed: #95979 - C - substantiated #95982 - I - substantiated During the course of this investigation the DIA Investigator determined there was a high risk of serious harm, injury, and/or death due to the facility's failure to assess and provide wander guard intervention to a resident that exhibited wandering/elopement behaviors with increased confusion. The facility also failed to ensure that an exit was alarmed thereby allowing a wandering resident the ability to elope. IMMEDIATE JEOPARDY declared 02/23/21 The facility initiated corrective action and removal of the state of IMMEDIATE JEOPARDY was verified onsite by the investigator on 02/23/21.	F 000	See attached plan of correction	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacy Jones — TITLE: Administrator — (X6) DATE: 3-16-21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interviews the facility failed to provide assessment/intervention and supervision for one of five residents when the resident exhibited increased confusion and verbalized a desire to exit the facility. (Resident #1). Facility front entrance/exit door not alarmed allowing Resident #1 to exit the facility without staff knowledge, resulting in immediate jeopardy to health and safety.The facility reported a census of 27 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated 12/10/2020, Resident #1 had severe cognitive impairment, no wandering behaviors exhibited, transferred from one surface to another with extensive assistance of two staff, and had diagnoses including hypertension, diabetes, dementia and osteoarthritis. The Care Plan indicated Resident #1 had	F 689		

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F 689	Continued From page 2 cognitive loss/dementia, history of TIA (Transient Ischemic Attack) (stroke) as evidenced by deficits in short and long term memory, initiated on 09/4/2020. The Care Plan instructed staff to use environmental cues and gestures to assist with communicating and to promote memory and problem solving, keep routine consistent, anticipate needs if unable to do so, ask yes/no questions if having difficulty responding to open ended questions and present just one thought, idea, question or comment at a time if having difficulty comprehending. On 02/10/2021, the Care Plan added Impaired behavior related to diagnoses of age related cognitive decline as evidenced by wandering and leaving the household. The Care Plan directed staff to intervene as necessary to ensure safety of resident and others, divert attention from stimulus, attempt redirection, Accu-tech (Wander Guard) monitoring device, and when wandering ask what he is looking for and assist as appropriate. Interdisciplinary Notes include the following nurse's notes: -11/22/2020 at 11:38 p.m. - Resident had confusion shift. At 9:00 p.m. he came out of his/her room with coat on, and a bag of apples thinking his son was coming to pick him up. Resident asked how to get to the stairs so he could leave. Staff tried to re-orient resident but the resident disagreed. Staff called the resident's daughter to talk to the resident and the resident asked her when she was coming to get him. After talking to the daughter, resident stated he would stay with them that night, and staff brought the resident back to his room and helped with night time cares. Daughter called back after an hour to	F 689		

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F 689	Continued From page 3 check on the resident. -02/10/2021 at 4:24 a.m. - Resident up at 2:00 a.m. and got dressed, found sitting in recliner. At 4:00 a.m. resident was observed about to self-transfer again, assisted to the bathroom and back to recliner. Resident then came out of room walking behind wheel chair. Nurse put a gait belt on the resident, grabbed the walker and ambulated up the hallway for a bit. Resident confused to place and time, looking for a way out. Resident re-directed back to his room and recliner. Resident refused snack, re-oriented to call light and placed within reach. -02/10/2021 at 6:48 a.m.- Staff B, Registered Nurse (RN), documented, Resident confused to time and place. Self-transferring, asking to go home, left household and returned by another staff person. Resident unable to say where he was going. -02/10/2021 at 2:44 p.m., the physician ordered a urinalysis and directed staff to monitor the resident's blood pressure for five days. 02/10/2021 at 5:45 p.m., Social Services added a new goal to the Care Plan due to resident leaving the household and wearing an Accu-tech device. The Elopement Incident Report dated 02/10/2021 reported Staff A, Housekeeping, observed Resident #1 sitting in between the two front entrance doors. When Staff A pulled up and stopped her car, the resident opened the door and wheeled out about two feet. Staff A immediately assisted resident back into the building and household and notified the nurse. Resident #1 Elopement/Wandering Assessments	F 689		

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F 689	Continued From page 4 included: -02/10/2021 - Score of 22. Resident at risk for elopement/wandering. -12/10/2020 - Score of 8. Resident not at risk for elopement/wandering. 10 or more = risk. Surveyor observation on 02/18/2021 at 11:30 a.m. revealed Resident #1 seated in his wheel chair, pleasant, neatly dressed and wearing an Accu-Tech Wander Guard bracelet on the right ankle. The resident sat calmly in his room. When asked if had gone outside lately? Resident replied with a smile, "Yes I did, someone told me I had better get back inside. It was slippery out there. I went out the back." Observation of facility camera surveillance footage from 2/10/2021 revealed: -At 6:09 a.m., a staff entered the facility. -At 6:17 a.m., Staff A pulled up to the front entrance -At 6:17:48 a.m., Resident #1 self-propelled out the door in his wheel chair and Staff A brought the resident back inside. Climatologist report: February 10, 2021 at 6:00 a.m. Dubuque airport reported a temperature of 2 degrees Fahrenheit with a negative 14 degrees Fahrenheit wind chill. During an interview on 02/18/2021 at 11:10 a.m., Staff D, RN, Director of Nursing (DON), revealed staff witnessed Resident #1 in his room seated in the wheel chair on 02/10/2021 at approximately 6:10 a.m., the resident reported he went through the therapy room to the front door and waited for a ride. Staff A arrived and observed the resident exit barely outside the door, approximately 1-2 feet. Staff A asked the resident where he planned	F 689		

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F 689	Continued From page 5 on going. The video indicated the incident occurred at 6:17 a.m.. During an interview on 02/18/2021 at 2:00 p.m., the Administrator revealed at the time of the incident, Resident #1's household only had a Wander Guard type alarm on its exit into the corridor. After the incident, they added a wireless keypad system that requires staff or visitor to enter a code. The front entrance/exit has a Wander Guard system located in the hallway leading to the door. Anyone without a Wander Guard can exit. In order to enter the facility, each staff carries a FOB that they scan to release the door. A visitor has to call for assistance by ringing the doorbell. The Administrator revealed the front entrance reception desk is staffed from approximately 7:30 a.m. until 4:30 - 5:00 p.m. Monday through Friday. During an interview on 02/23/2021 at approximately 11:45 a.m., the Administrator revealed he began working at the facility in April 2020, the front entrance had no functioning keypad alarm, only a Wander Guard alarm when exiting the facility. It had the capability for an additional alarm, and a key pad had been in place prior to the pandemic. The Administrator learned the front entrance keypad alarm had been disabled since they were not allowing visitors during the pandemic. On 02/18/2021, maintenance moved the keypad alarm to the Conlon household as an additional precaution until a new FOB system could be installed. During an interview on 02/22/2021 at 2:15 p.m., Staff B, RN reported working the night shift on 02/9/2021 from 6:00 p.m. until 6:00 a.m. on 02/10/2021. Staff B reported the resident often	F 689		

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F 689	Continued From page 6	F 689		

got up during the night, got dressed and self-transferred. Throughout the shift, staff checks the resident and ask him to use the restroom, however the resident often refuses. The resident fails to ask for assistance. That early morning on 02/10/2021, the resident self-transferred from the bed to wheel chair, got dressed, and sat in the recliner. Around 4:00 a.m., the resident came out of the room and stated, "I'm trying to find a way out." Staff B put a gait belt on the resident, walked for a bit and then assisted the resident to the recliner. Staff B informed the resident there had been a big snowstorm the night before. The resident seemed satisfied to return to the recliner and made no further remarks. Staff B recalled a long time ago the resident made a similar confused statement, and indicated he wanted to wait for the bus to go to St Anthony's Church. The resident never went to the door and attempted to exit the facility.

During an interview on 2/22/2021 at 2:30 p.m., Staff C, RN reported working on 02/10/2021 from 6:00 a.m. until 6:00 p.m.. At approximately 6:10 a.m., Staff C observed Resident #1 seated in the wheel chair in his room doorway. Staff C went to care for another resident and the two Certified Nurse Aides (CNA's) were busy assisting residents. A little while later, Staff A reported he brought the resident back. Staff C, surprised and unaware the resident left the household immediately put the Wander Guard bracelet on the resident. Staff C indicated the resident had no prior attempts to exit the household.

During an interview on 02/22/2021 at 10:00 a.m., Staff A, Housekeeping, reported she typically arrived to work early, pulls up to the front entrance and goes inside to the reception area.

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F 689	Continued From page 7 Staff is required to have Covid-19 screening prior to starting her shift. As Staff A approached the entrance, she noted Resident #1 seated inside the door. Staff A thought the resident possibly had an appointment and waited for transportation. As Staff A exited the car, the resident exited the front doors and Staff A assisted the resident back inside the building. The resident had no coat on and stated he "was going home". Staff A returned the resident to the household and the resident said, "There's my room". Staff A reported the incident to Staff C. Staff A revealed the resident's daughter drives a similar vehicle. Staff Education provided after the incident included: Staff are required to respond to all alarms in the facility. If it is noted that a resident has increased confusion or is noted to make statements regarding leaving the facility, an Accu-tech is to be applied immediately. During an interview on 02/25/2021 at 12:10 p.m., Staff E, Maintenance reported that initially the Conlon household had no FOB system, only a Wander Guard type system. Butler household had both a FOB and Wander Guard system. Staff E indicated he currently reached out to vendors and waited for bids to add a FOB system in Conlon. The front entrance initially had a keypad alarm system, however they disabled it when the facility prohibited visitors during the pandemic. Staff used an employee entrance at that time. The facility Policy and Procedure for Elopement, Risk Prevention and Management of Missing Residents dated 06/09/2019 included: Policy: Luther Manor Communities - Grand Meadows Campus strives to promote resident	F 689		

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F 689	Continued From page 8 safety and protect the rights and dignity of the residents. The facility maintains a process to assess all residents for risk for elopement, implement prevention strategies for those identified as an elopement risk, institute measures for resident identification at the time of admission and conduct a missing resident procedure. Procedure: A. Assessment 1. An elopement risk assessment is completed by the nursing staff on all residents on admission, quarterly and upon change of condition. 2. A facility approved risk assessment tool is utilized. The assessment is based on various risk factors that may precipitate an elopement event. The risk score includes a defined parameter which, when reached, indicates an increased risk and prompts prevention strategies. B. Prevention 1. Interventions that may be used for residents identified as high risk for elopement include: a. Designate resident as an elopement risk b. Place an Accu-tech bracelet on him/her. c. Include in activities that are in full view of staff d. Notify the staff of which residents are at risk for elopement e. Develop an elopement Care Plan f. Update families g. Transfer to a secured unit as needed The situation detailed above resulted in Immediate Jeopardy (IJ) for the facility. The facility was notified of the Immediate Jeopardy on 02/23/21. The facility removed the IJ situation on 02/23/21. The scope and severity of the deficiency was lowered from a "J" to a "D." The facility removed the IJ by placing an alarm system on the facility front door (Wire Response Care	F 689		

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F 689	Continued From page 9 keypad) which audibly alerts to the pagers of staff members, the nurses' company cell phones, and the message boards in the households. Wander guards were applied to all mobile residents in the Conlon Household and staff education was provided to include: 1. Resident(s) that experience increased confusion or is noted to make statements regarding leaving the facility, a wander guard will immediately be applied. Social worker and MDS Coordinator to be notified of the change. Family notification to occur. 2. Staff shall not change the settings on the household cell phone to silence or turn off notifications related to door alarms. 3. Nurse shall notify the Administrator or Director of Nursing immediately following an elopement or attempted elopement. Grand Meadows provided further staff education on February 23, 2021, to include: 1. It is the responsibility of all staff to respond to a door alarm. 2. Staff must check the alarming door and its immediate surroundings. If no one is visible or there is no cause seen for the alarm to sound, then a complete check of all households will be done and all residents must be accounted. 3. Staff shall respond to an alarm immediately. If alarms are noted to be on for an extended period of time, all staff working at the time will be subject to disciplinary action. 4. Staff will appropriately use the alarms while entering and exiting facility. 5. Nurses' cell phones and C.N.A./C.M.A. pagers are to be carried at all times. These are part of the uniform. Random audits will be conducted.	F 689		

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F 689	Continued From page 10 Observation on 02/23/2021 at 3:40 p.m. revealed the facility front entrance/exit door had a wireless keypad alarm installed and functioned. The Administrator demonstrated the function of the recently installed alarm for the surveyor. On 02/18/2021, maintenance staff moved the keypad alarm from the front entrance door to the Conlon household. On 02/23/2021, maintenance staff moved the keypad alarm from the Conlon household to the front entrance/exit door.	F 689		

LUTHERMANOR
COMMUNITIES

HILLCREST CAMPUS
Care Center:
3131 Hillcrest Road, Dubuque, IA 52001
p:563.588.1413 | F:563.588.3875

Apartments:
3129 Hillcrest Road, Dubuque, IA 52001
p:563.588.1413 | F:563.588.3875

ASBURY CAMPUS
Assisted Living & Care Center:
5300 Grand Meadow Drive, Asbury, IA 52002
p:563.690.71503 | F:563.690.9348

The Residences:
5284 Grand Meadow Drive, Asbury, IA 52002
p:563.557.7662 | F:563.690.9348

LUTHER MANOR COMMUNITIES – GRAND MEADOWS PLAN OF CORRECTION

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.

F689 483.25(d)(1)(2) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

It is the practice of this provider to ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

Based on the information provided, Resident's #1 care plan and elopement risk were reviewed. Resident #1 had a wander guard placed on him on February 10, 2021. The care plan was updated to reflect appropriate elopement risk interventions on February 10, 2021.

All residents that are at risk for elopement have the potential to be affected by the deficient practice. The interventions and care plans for residents at risk for elopement have been reviewed to ensure compliance on February 25, 2021. Residents care planned for a wander guard were reviewed to ensure the wander guard is in place by the Director of Nursing or her designee.

Nursing staff were re-educated on elopement risk interventions on February 10, 2021 and February 23, 2021, by the Director of Nursing. Nursing staff were re-educated on elopement risk by online course MEM508: Wandering & Elopement in LTC interventions by February 28, 2021. Course addresses knowing who is at risk and what to do if a resident wanders or elopes. Nursing staff were required to complete a post-test following the course.

The Interdisciplinary team will continue to meet weekly and will utilize the tool entitled "Elopement Risk Assessment" to monitor residents' risk for elopement for a three-month period and then thereafter on a monthly basis to ensure compliance. The Director of Nursing or designee will be responsible to monitor for compliance. Further, the MDS Nurse will continue to review each resident's care plan quarterly and as needed to reflect residents' needs regarding elopement risk. The MDS Nurse will ensure that resident's elopement risk interventions are in place on a quarterly basis.

On February 23, 2021, the facility installed an alarm system on the facility front door (Wire Response Care keypad) that audibly alerts to the pagers of staff member, the nurses' company cell phones, and message boards in the households. Confirmed by DIA Surveyor on February 23, 2021.

Completion Date: March 3, 2021