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
	S0261	A. BUILDING: ______ B. WING ______	C 07/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD ESTATES AT HAWTHORNE CROS	601 HAWTHORNE CROSSING DR. SE BONDURANT, IA 50035

(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	481-67 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: 24 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 26 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 4 Number of tenants with cognitive disorder: 21 Total Population of Program at time of on-site: 25 TOTAL census of Assisted Living Program: 51 No regulatory insufficiencies were found during the investigation of Complaint 61287-C. The following regulatory insufficiencies were cited during the investigation of Incident 61269-I :	A 000	See attached POC 8/5/16	
A 013	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: (Incident 61269-I) Based on interviews and review of tenant	A 013		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 013	Continued From page 1	A 013		

documents, the Program failed to ensure a tenant received services as directed by service plans. The Tenant did not receive care, treatment and services which were adequate and appropriate.

Tenant #1, a 92 year-old, was admitted on 7-3-13 and diagnoses included: unspecified dementia without behavioral disturbances, disease of upper respiratory tract, edema, sleep apnea, hypertension, arthritis and enlarged prostate. Tenant #1 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #1 resided in the dementia unit.

Review of Tenant #1's service plan, dated 8-19-15, indicated Tenant #1 required visual checks eight times a shift. Review of tasks sheet indicated Staff B provided a visual check at 10:00 p.m.; however, during interview, Staff B admitted she did not see Tenant #1 at 10:00 p.m. Staff B had asked Staff A if she had seen Tenant #1 at 10:00 p.m. Staff A told Staff B she had seen Tenant #1; however that was not true and during interview, Staff A stated, she had not checked on Tenant #1 at 10:00. Further review revealed a check documented at 9:00 p.m. by Staff A. Staff did not provide eight visual checks per shift as specified in Tenant #1's service plan.

On 7-4-16 Tenant #1 eloped from the dementia unit through an unlocked courtyard gate. Staff working on the dementia unit did not realize Tenant #1 was gone until approximately 12:10 a.m. According to the manager, she received a call at approximately 12:34 a.m. stating Tenant #1 had been located. Based on documentation of visual checks, staff did not know Tenant #1's whereabouts for 3 hours and 34 minutes.

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A 013	Continued From page 2 Tenant #1 did not receive care, treatment and services which were adequate and appropriate when staff failed to complete visual checks as required by the service plan.	A 013		
A 138	481-69.32(2) Life Safety 481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements. 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: (Incident 61269-I) Based on interviews, the Program failed to have an operating alarm system on exit doors in a dementia unit. Tenant #1, a 92 year-old, was admitted on 7-3-13 and diagnoses included: unspecified dementia without behavioral disturbances, disease of upper respiratory tract, edema, sleep apnea, hypertension, arthritis and enlarged prostate. Tenant #1 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #1 resided in the dementia unit. The Program reported on 7-4-16 at approximately 12:10 a.m. staff noticed Tenant #1 was not in his/her apartment. Staff C, who had come to dementia unit to check with staff, noticed that Staff A and B were locked out of the unit. When Staff C opened the door, Staff B explained that	A 138		

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A 138	Continued From page 3	A 138		

Staff A had knocked on the window because when she drove around the building to deposit trash in the dumpster she noticed the gate to the dementia unit courtyard was open. When interviewed, Staff A said she thought she noticed the gate was open around 11:30 p.m. Staff B and C completed apartment checks and discovered Tenant #1 was missing at approximately 12:10 a.m. Staff called 911, the nurse and the manager and started a search. According to the manager, she received a call at approximately 12:34 a.m. stating Tenant #1 had been located in a grassy area, lying on the ground. Staff C said Tenant #1 was wearing jeans, a long sleeved shirt, socks and shoes.

The monitor observed the distance from the door of the dementia unit to the area where Tenant #1 was located to be approximately 75 to 100 yards. A corn field was also located approximately 50 yards from Tenant #1's location. The South door of the dementia unit measured .2 miles via the driveway to Highway 330 where the posted speed limit was 55 miles per hour.

Review of Device Activity Report for the alarms revealed on 7-4-16 a breach of the South (S1) door leading to the courtyard at 7:55 p.m. According to the report, the reset time was 212 minutes and 44 seconds later. At 11:28 p.m. the reported noted an interface clear. When interviewed, Staff C said she went to the office and manually reset the alarm as she had checked it several times and attempted to reset it but could not.

The Program's dementia unit did not have an operating alarm system on the South door for three hours and 32 minutes. Based on interviews and documentation, Tenant #1 was missing and

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A 138	Continued From page 4 unaccounted for for three hours and 34 minutes.	A 138		
A 154	481-69.35(1)b Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: (Incident #61269-I) Based on interviews and a review of incident reports, the Program's courtyard gate was not locked/secured. Tenant #1, a 92 year-old, was admitted on 7-3-13 and diagnoses included: unspecified dementia without behavioral disturbances, disease of upper respiratory tract, edema, sleep apnea, hypertension, arthritis and enlarged prostate. Tenant #1 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #1 resided in the dementia unit. The Program reported on 7-4-16 at approximately 12:10 a.m. staff noticed Tenant #1 was in not his/her apartment. Staff C, who had come to dementia unit to check with staff, noticed that Staff A and B were locked out of the unit. When Staff C opened the door Staff B explained that Staff A had knocked on the window because when she drove around the building to deposit trash in the dumpster she noticed the gate to the dementia unit courtyard was open. When interviewed, Staff A said she noticed the gate was	A 154		

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A 154	Continued From page 5 open at around 11:30p.m. Staff B and C completed apartment checks and discovered Tenant #1 was missing at approximately 12:10 a.m. Staff called 911, the nurse and the manager and started a search. According to the manager she received a call at approximately 12:34 a.m. stating Tenant #1 had been located. Review of documentation showed Staff D documented she had checked the gate at beginning and end of her 2 -10 shift on 7-4-16. When interviewed, she admitted she had not checked the gate as she had documented. Interviews and documentation confirmed staff failed to complete checks of the gate on the dementia unit courtyard resulting in Tenant #1's elopement. According to interviews and review of documentation Tenant #1 was missing for at least three hours and 34 minutes.	A 154		

Vgk 8/5/16

Courtyard Estates at Hawthorne Crossing
601 Hawthorne Crossing Drive SE
Bondurant, Iowa 50035

Date: 8/1/16

Complaint Intake #: 61289-I, 61287-C

HEALTH FACILITIES

AUG 04 2016

Plan of Correction (POC) Submitted For:

- Investigation Date: July 7,11 and 12, 2016

A. **Regulatory Insufficiency: 481-67.3(2) Tenant Rights** All residents have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate.

Program POC:

1. Elements detailing how insufficiency was corrected for residents:

(a) The Program RN and Manager completed training on resident service plans and visual checks in the electronic healthcare system on 7/7 through 7/11/16 and again on 7/15/16.

2. Actions the program is taking to protect tenants in similar situations:

(a) Tenant #1 no longer resides at CYE Bondurant.

(b) Program RN and Program Manager provided staff re-education on Residents Rights for cares, treatments and service as it pertains to the resident specific service plan for documentation of completion of resident visual checks and elopement policy on 7/7/16 through 7/11/16.

(c) The Program RN and Program Manager provided staff education on Visual checks as outlined in current and updated ISPs for residents residing in Memory Care on 7/15/16.

(d) The Program RN and Program Manager completed disciplinary action through written warnings to Staff A, D on 7/6/16 and Staff B on 7/7/16. Staff D was suspended 7/29/16. Staff A was suspended on 7/30 and Staff B was suspended on 7/31/16 upon receipt of the final report from the Department. Staff A, B and D were terminated 8/2/16.

(b) The Program RN/designee will complete random hands-on monitoring during scheduled Point of Care tasks in Memory Care for 14 days starting 8/3/16.

B. **Regulatory Insufficiency: 481.69.32(2) Life Safety:** *Life safety –emergency policies and procedure and structural safety requirements. 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.*

Program POC:

(1) Elements detailing how insufficiency was corrected for residents:

(a) The Program door alarm system to the Memory Care Courtyard was determined to be have been functioning correctly during the hours reviewed by the Department Monitor. The Stanley Health Care technician assessed this on 7/12/16. The system was not able to be reset at the point of the exit door to courtyard as reported by the program staff after the manager had arrived in the community on 7/5/16 at 12:55 am. The door alarm was manually reset on the system computer by Staff C on 7/4/16 at 11:28 pm. The alarm system remained engaged.

(2) Actions program taking to protect tenants in similar situations:

(a) The Program RN completed education with all staff on the Memory Care on the door alarm system which was functioning appropriately. In the event the system does not the Program RN will retrain on the procedure to take if the door alarm is not functioning appropriately, including 15-minute safety checks. This education was completed 7/6-7/15/16.

(b) The Program RN completed education on the Program's Elopement Policy with all staff between 07/07/16 through 07/11/16

(3) Measures taken to ensure problem does not recur:

(a) Additional training on the Program Memory Care alarm system was completed by a Stanley technician with the Program Manager, Nurse, and Maintenance Coordinator on 7/15/16.

(b) The security access was changed on the main emergency response computer by the Stanley Health Care technician which allows only the Program Manager to clear and reset the door alarm system on 7/15/16.

(c) The Memory Care door alarm report is monitored randomly by the Program Manager and Program RN and/or designee to beginning 8/3/16.

(d) Memory Care door alarm checks will be physically checked by staff per shift change to ensure the system sends an alarm appropriately beginning 8/3/16. Physical checks will include opening the door to trigger the alarm and receiving the alert on the staff radio headset.

(e) Random Memory Care checks will be completed by Program Manager, Program Nurse or designee beginning 8/3/16. The emergency alarm system report, shift-to-shift alarm checks by Memory Care staff and random checks will be emailed to the designated department coordinator bi-weekly on Tuesday and Fridays beginning 8/5/16.

4. Program plans to monitor performance to ensure solutions are permanent:

The Program Manager or Program Nurse will monitor the Memory Care door alarm reports randomly starting 8/3/16. The Program Manager, Program Nurse or designee will monitor the shift change door alarm check documentation daily for 30 days starting 8/3/16. The Program Manager, Program Nurse or designee with monitor The Random Memory Care check documentation for 30 days starting 8/3/16.

C. ***Regulatory Insufficiency: 481.69.35(1) b Structural***: *Structural requirements. 69.35(1) General requirements. b. The building and grounds shall be well-maintained, clean, safe and sanitary.*

Program POC:

1. Elements detailing how insufficiency was corrected for residents:

(a) The Memory Care Program gate in the Courtyard was determined to have been left unlocked. Internal investigations conducted by the Program RN, and Program Manager, have not been conclusive on what staff member unlocked the gait and failed to secure. The

Program RN and Program Manager and will continue staff interviews to determine the breach in protocol and follow through with disciplinary action as appropriate.

2. Actions the program is taking to protect tenants in a similar situation:

(b) The program will physically inspect Memory Care Courtyard gate locks on all shifts at the time of shift change beginning 8/3/16.

(c) Random Memory Care exit door and gates checks will be completed by Program Manager, Program Nurse or designee daily beginning 8/3/16 daily for 14 days.

(d) The emergency alarm system report, shift change visual check of Memory Care gate and random checks will be emailed to the designated department coordinator bi-weekly on Tuesday and Fridays beginning 8/5/16.

3. Measures taken to ensure problem does not recur:

(a) The Memory care staff are completing visual checks of all memory care exits and memory care gates starting 8/3/16.

(b) An additional Memory Care electronic gate alarm was installed by Stanley Healthcare on 7/12/2016 which alerts the staff when the gate is opened. This automatically resets when the gate is closed. The alarm will register on the emergency alarm computer system. The system as well as the staff radios and headsets will be notified when the battery needs changed on the gate alarm.

4. Program plans to monitor performance to ensure solutions are permanent:

(a) The Program Manager, Program RN or designee will monitor the Memory Care gate randomly to ensure that the gate is alarmed and in working order. This will begin 8/3/16, then weekly for 14 days and then as scheduled by the Program Manager.

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.