10-28-19

PRINTED: 09/24/2019
FORM APPROVED

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
	S0317	A. BUILDING: _____ B. WING _____	C 08/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAUKEE MEMORY CARE LLC	1505 SE LAUREL STREET WAUKEE, IA 50263

(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. Dementia-Specific Program by Definition Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 16 Total Census of Assisted Living Program for People with Dementia: 17 As the result of the re-certification survey and investigation # 85321-I, the following regulatory insufficiency was written.	A 000	This plan of correction constitutes our credible allegation of compliance. The following deficiencies were corrected by 10/24/19. Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the federal and state law.	
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: Based on observations, interviews, and record review the facility failed to ensure door alarms were installed on all exit doors of the Program. This affected 1 of 1 client (Client #1) identified in the program's self-reported incident #85321-I, and potentially affected all tenants residing in the Program. Finding follows:	A 138	In Response to A 138: A. Walsh Doors was contacted on 8/28/19 to install alarms on the main entrance doors as well as the door on the north side of the lobby. The alarms were ordered on 9/25/19. They are scheduled to be installed on or before 10/24/19. B. The maintenance director or designee will check all alarmed doors on a routine basis to ensure they are properly working. This will be reviewed at the bi-monthly QAPI meeting. C. Elopement drills are done on a routine basis to ensure staff understand what to do in the event of an elopement. This will be reviewed at the bi-monthly QAPI meeting.	

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A 138	Continued From page 1 Record review of Tenant #1's file revealed he moved into the program on 4/25/19 with Lewey Body Dementia, Parkinson's disease, and a history of falls. He scored 6 on the Global Deterioration Scale (GDS). Review of incident report dated 6/21/19 revealed at approximately 7:50 p.m., Tenant #1 walked with his walker and a neighbor approximately one block to the long term care facility's parking lot. A nurse from the long term care facility observed him in the parking lot with a tee shirt, jeans, socks, and shoes on. The nurse and the tenant's wife who lived in the independent living part of the building, walked the tenant back to the program. Upon return to the building, the tenant was assessed and no injuries were found. According to the program's investigation of the incident, Tenant #1 received medication at approximately 7:10 p.m. Staff A left the building at approximately 7:30 p.m. to go on break. It was possible Tenant #1 followed Staff A out the alarmed doors to the entry way and then went out the unalarmed front doors into the parking lot. At approximately 7:30 p.m., Tenant #1's wife saw Tenant #1 and a neighbor walking across the parking lot toward the long term care building. At approximately 7:33 p.m. the nurse from long term care and the tenant's wife or another staff member accompanied Tenant #1 back to the memory care program. Staff A's statement to the program described her completing cleaning tasks prior to going on break at about 7:30 p.m. She said Tenant #1 tried to leave through a back door earlier in the shift, but the door alarm sounded and she redirected him back to the common area on the couch. Staff A	A 138		

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A 138	Continued From page 2 no longer works at the program. During Staff B's interview with the program administrator she reported she gave Tenant #1 medication around 7:10 p.m., then continued the medication pass with other tenants. Tenant #1 was near the door to the nurses station when she gave him medication. Staff B confirmed Tenant #1 had tried to exit out the back door earlier in the shift, around 4:00 p.m., and Staff A redirected him to the couch. Staff B no longer works at the program. When interviewed on 8/30/19 at 2:00 p.m. Staff C recalled she worked in the kitchen the evening Tenant #1 eloped from the program. She said she washed dishes until approximately 7:30 p.m. and then went to the nurse's station to do paper work. At 7:30 p.m., Staff A said she was leaving on break. Staff C watched Staff A walk out of the memory care doors and said Tenant #1 did not follow her out. Staff C reported at about 7:45 p.m. Staff A returned to the program and said Tenant #1 had been found walking outside. Staff C said she didn't recall family members present in the program that evening, but that family members of tenants did have the code to get out of the memory care doors. Staff C did not hear the alarm on the memory care doors go off that evening either. She said it was still unknown how Tenant #1 left the program. She noted at times Tenant #1's gait was steady and he could walk at a rapid rate of speed with his walker, and other days his balance and gait was not very good. During the recertification survey and investigation on 8/27/19 at approximately 2:00 p.m., this surveyor exited the two sets of exit doors at the	A 138		

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A 138	Continued From page 3 front of the building. No alarm could be heard upon opening the doors. At approximately 2:30 p.m., the Licensed Practical Nurse (LPN) and the Registered Nurse (RN) confirmed there were no alarms on the front doors or alarms that sounded on staff pagers. They both said they thought the alarms on the doors from the memory care unit out into the entry way were enough and didn't think the front doors needed alarms. When interviewed on 8/28/19 at 9:30 a.m., the program administrator said she didn't think they needed alarms on the front doors because there were alarms on the doors from the memory care out into the lobby. She also confirmed the exit door off the lobby opening to the outside of the back of the building was not alarmed. She added she had been in contact with the alarm company to have alarms installed on front and back exit doors.	A 138		