✓ 2/3/20 OK 11/30/2020

PRINTED: 12/24/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALPD367 HFD	A. BUILDING _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYHOUSE RESIDENCES	1831 EAST KANESVILLE BLVD COUNCIL BLUFFS, IA 51503

(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 disorder: 0 Number of tenants with cognitive disorder: 30 TOTAL Census of Assisted Living Program for People with Dementia: 30 The following regulatory insufficiencies were cited during the investigation of Complaint #86497-C:	A 000	See attached POC 11/24/2020	
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, interview and record review the Program failed to consistently ensure an operating alarm system existed on the exit door. This affected 1 of 1 tenant (Tenant #1) identified in incident investigation 86497-I. Finding follows: Record review on 10/16/19 revealed an Incident Report dated 9/16/19. Tenant #1 had been redirected to the movie room. Staff returned to check on on Tenant #1 approximately 10 minutes later and noted Tenant #1 was no longer in the	A 138		

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

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A 138	Continued From Page 1 movie room. Staff checked A side hallway and rooms and were unable to locate the tenant. Staff checked B side hallway and rooms and noted the North door was unlatched. Staff did not locate the tenant within the building. Staff notified Program nurse of possible elopement. While staff were on the phone with the Program nurse Council Bluffs Police Department called to report they had picked up Tenant #1 on Kanesville boulevard and were in route to return Tenant #1 to the Program. Tenant returned with no noted injuries and denied pain. Record review revealed Tenant #1 staged at a six on the Global Deterioration Scale. Tenant #1's Service Plan, dated 9/22/19, indicated Tenant #1 required 24-hour supervision and further noted the tenant may wander throughout the halls and other tenant rooms throughout the night. A motion sensor had been placed in Tenant #1's doorway to alert staff of the tenant's wandering from his room. When interviewed on 10/15/19 at 5:30 p.m. Staff A said Tenant #1 had been seated in the movie room around 7:30 p.m. She was administering medications when a call came over the walkie talkie asking about Tenant #1's whereabouts. She said they called the nurse and began to search the building for Tenant #1. Staff A said she did not hear the alarm announce the North door had been opened. When interviewed on 10/15/19 at 5:40 p.m. Staff B said Tenant #1 had been seated in the movie room around 7:30 p.m. and when Staff C said she couldn't locate him, they started a search of the building and during the search staff noticed the North door was not latched. Staff B said she did not hear the alarm announce the North door had been opened and had not noticed Tenant #1 exit seeking earlier in the day.	A 138		

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A 138	Continued From Page 2 When interviewed on 10/15/19 at 5:50 p.m. Staff C said Tenant #1 had been seated in the movie room around 7:30 p.m. and when she checked he was not there. She announced over the walkie talkie and the staff started a search for Tenant #1. During the search they noted the North door was not latched. Staff C said she did not hear the alarm announce the North door had been opened. When interviewed on 10/16/19 at 2:12 p.m. Staff D said Tenant #1 had been seated in the movie room around 7:30 p.m. She went to chart his inappropriate behavior towards another tenant She said Staff C asked about Tenant #1's whereabouts. Staff started a search for Tenant #1 and noted the North door unlatched. Staff A said the alarm did not announce the North door had been opened. When interviewed on 10/15/19 the Program's Nurse explained the door was closed yet the alarm was not armed when she checked it upon arrival to the Program. Record review on 10/16/17 revealed Care History For Building which documented a door check was performed at 3:12 p.m. on 9/16/19. When interviewed on 10/16/19 at 2:20 p.m. the Executive Director confirmed the Program did have a policy/protocol to ensure exit door alarms were functioning properly. She explained that staff had been checking the door alarms but the Program had not developed a policy/protocol that included documenting the checks of door alarms.	A 138		

OIC 1/30/2020

December 30, 2019

HEALTH FACILITIES
JAN 14 2020

2/3/20

Department of Inspections and Appeals
Attn: Catie Campbell
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Campbell:

On behalf of Country House Residences in Council Bluffs, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Monitoring Report for dated December 24, 2019. 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 insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of state law.

Life Safety

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - All exit doors will be alarmed as required by regulation.

2. What measures will be taken to ensure the problem does not recur.
    - All staff were educated on policy/procedures for checking door alarms to ensure they are working properly. Staff also educated on ensuring doors shut and latch when exiting and entering.

3. How the Program plans to monitor performance to ensure compliance.
    - The Administrator, Maintenance, and or Designee will inspect doors at least monthly to ensure they are latching as appropriate. In addition, door alarms will be tested at least monthly to ensure they are working appropriately.

4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be corrected by January 24, 2020.

If you have any questions regarding this plan of correction, please feel free to contact me at 712-322-4100. Thank you.

Sincerely,

Shelly Otten

Shelly Otten
Administrator