

✓ 9/17/16
JHL

PRINTED: 08/17/2016
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IAADS012_HFD	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/03/2016
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NAME OF PROVIDER OR SUPPLIER PATHWAYS ADULT DAY HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 817 PEPPERWOOD LANE IOWA CITY, IA 52240
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(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 Adult Day Service 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 participants without cognitive disorder: 48 Number of participants with cognitive disorder: 18 Total Population of Program at time of on-site: 66 TOTAL census of Adult Day Service Program: 66 An investigation of Incident #61953-I was completed. There was a regulatory insufficiency identified related to the investigation of Incident #61953-I.	A 000	See attached Plan of Correction DD POC 8/2/16	
A 210	481-70.35(1) Structural Requirements 481-70.35(231D) Structural requirements. 70.35(1) The structure, equipment and physical environment of the program shall be designed and operated to meet the needs of the participants. The building, grounds and equipment shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: Based on review of a participant file, staff interviews, observations and review of documents, the Program failed to have equipment which was well-maintained.	A 210		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 210	Continued From page 1 Participant #1's service plan indicated he/she demonstrated behaviors that might be consistent with a high risk of elopement. As a result Participant #1 wore an electronic wandering monitoring device. Participant #1 eloped from the Program without staff knowledge. When returned to the building the alarm did not sound for the electronic wandering monitoring device. The electronic wandering monitoring bracelet worn by Participant #1 at the time of the elopement was expired and did not function. Findings include: 1. Participant #1, a 69 year old, began participation on 2-19-16 with diagnoses including Alzheimer's disease, depression and anxiety. Participant #1 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. According to a fax to the participant's doctor dated 6-9-16, Participant #1 had attempted to leave the Program on several occasions. There was concern for Participant #1's safety. Participant #1's spouse was in agreement with the participant wearing the electronic wandering monitoring device while in attendance. The doctor's order for the electronic wandering monitoring device was dated 6-13-16. A 90 day nurse review document dated 6-20-16 indicated Participant #1 wandered and an electronic wandering monitoring device was in place. According to a service plan dated by the Nurse on 3-18-16, Participant #1 demonstrated behaviors that might be consistent with a high risk of elopement. The service plan indicated an order was received for placement of an electronic wandering monitoring device.	A 210		

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A 210	Continued From page 2 According to Clinical Notes dated 7-15-16, Participant #1 and another participant were following a third participant to the courtyard. On the way to the courtyard Participant #1 and one of the participants found the culinary door and went out the door. The participant that was leading them got them to start coming back in when Staff A arrived. Staff A informed Participant #1 and the other participant that they could not go out the door because it did not lead to the courtyard. Participant #1 and the other participant were redirected to the courtyard doors. According to Participant #1's task sheet, the electronic wandering monitoring device was initialed (indicating placement) on 8-1-16. 2. According to an incident report, on 8-1-6 at 10:20 a.m. the Program was notified by a friend of Participant #1 that the participant was at a nearby business and appeared confused. Staff A brought Participant #1 back to the Program. Participant #1 was wearing the electronic wandering monitoring device, which did not sound when he/she re-entered the building. Participant #1 was assessed by the Nurse and no injuries were noted. Participant #1's spouse and the Department were notified. The electronic wandering monitoring bracelet was replaced with a working sensor. 3. According to an interview with Staff A, she had tested three electronic monitoring bracelets as part of her beginning duties on the day of Participant #1's elopement. All three bracelets functioned. The bracelets were checked everyday with the sensor. Participant #1 usually	A 210		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

PATHWAYS ADULT DAY HEALTH CENTER

**817 PEPPERWOOD LANE
IOWA CITY, IA 52240**

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A 210	Continued From page 3 arrived between 8:00 a.m. and 8:30 a.m. Another staff put the electronic wandering monitoring bracelet on Participant #1 on the day of the elopement. The Program received a telephone call from a person at a business reporting Participant #1 was there. Staff A and the Nurse checked the community room and Participant #1 was not there. Staff A drove to pick up Participant #1. Staff A did not hear the sensor go off prior to the telephone call (which would have indicated Participant #1 left). Staff A stated Participant #1 was most last seen shortly before the telephone call as when directed to activities in the community room. Participant #1 was wearing jeans, a blue shirt, shoes and socks at the time of the elopement as well as the electronic wandering monitoring bracelet. Participant #1 ambulated independently and did sustain any injuries related to the elopement. Participant #1 was returned to the Program but no alarm went off when he/she entered the building. The non-functioning bracelet was immediately replaced with a new bracelet. 4. According to an interview with the Nurse, Participant #1 came into the building and had breakfast. The electronic wandering monitoring bracelet was placed on him/her. A telephone call was received from a person at a business who indicated Participant #1 was there. Staff A picked up the participant and returned him/her with no injuries noted. No alarm sounded when Participant #1 returned to the building. The person who had picked up Participant #1 and taken him/her to the nearby business had found the participant on the corner of Keokuk Street and Highway 6. The Nurse said the electronic wandering monitoring bracelet Participant #1 was wearing at the time of the elopement had	A 210		

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A 210	Continued From page 4 expired. A new bracelet was put on Participant #1. It was tested and functioned. 5. According to an interview with the Director, the electronic wandering monitoring device did not alarm when Participant left the building or when Participant #1 returned to the building on the day of the elopement. The bracelet Participant #1 was wearing had expired and was not working. At the time of the investigation, all expired bracelets had been removed and all were current. Participant #1's spouse was contacted regarding the elopement and the Department was notified. Participant #1 did not have any injuries related to the elopement. 6. According to the State Climatologist, conditions at the local airport on 8-1-16 at 10:36 a.m. were as follows: temperature was 77 degrees, winds were from the southeast at nine miles per hour and there were mostly cloudy skies with no precipitation. 7. According to observation, the approximate distance by car from the Program's parking lot to the area where Participant #1 was located was 0.2 of a mile. The distance by foot took approximately 5 minutes and 30 seconds. Participant #1's elopement was not witnessed; however possible terrain Participant #1 traveled included city sidewalk, street and grass. 8. According to the Program's policy regarding the electronic wandering monitoring system, the Program used the system to help ensure safety for individuals deemed an elopement risk. When a participant was assessed as an elopement risk they were asked to wear an electronic wandering monitoring bracelet. The bracelet would trigger	A 210		

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A 210	Continued From page 5 the alarm system should the participant attempt to leave the building via the main entrance or the front entrance of the community room. Staff greeting the participant would place the electronic wandering monitoring bracelet on the participant upon arrival at the Program. The staff escorting the participant when leaving the Program for the day for would remove the bracelet. If the participant triggered the alarm system staff would immediately redirect the participant to another area and reset the alarm system. A monthly check of all bracelets and the electronic wandering monitoring system was to be conducted by the Program to ensure everything was working properly.	A 210		

Pathways Adult Day Health Center
Corrective Action Plan

JK
9/1/16

August 25, 2016

Tamara Brockrob, Certification Coordinator
Adult Services Bureau
Department of Inspections and Appeals
Health Facilities Division
321 East 12th Street, 3rd Floor, Lucas Building
Des Moines, IA 50319-0083

Dear Ms. Brockrob,

Below is Pathways Corrective Action Plan for the Regulatory Insufficiency identified on an Incident Investigation Report that took place on August 2nd and 3rd, 2016.

- **Structural Requirements**

Participant #1 eloped the facility on August 1, 2016. The Wander Guard Bracelet she was wearing was found to be expired and did not sound the alarm when she left the program.

The Wander Guard bracelet was immediately discarded when the participant was returned to the program on August 1st and was replaced with a current Wander Guard. Staff have begun documentation that a test of each bracelet and that it is in good working order is completed as of August 2nd, 2016. Staff will also monitor dates daily and will discard any Wander Guards with an expired date.

Please let me know if you require any additional information or if you have questions.

Sincerely,

Jeff Kellbach, Director
Pathways Adult Day Health Center
817 Pepperwood Lane
Iowa City, IA 52240

JK
9/7/16