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 08/05/2020

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	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. General Population Number of tenants without cognitive disorder: 19 Number of tenants with cognitive disorder: 6 Memory Care Unit Number of tenants without cognitive disorder: 3 Number of tenants with cognitive disorder: 17 Total census: 45 No regulatory insufficies were cited regarding the onsite infection control survey. The following regulatory insufficiencies were cited during the investigation of Complaints #91390-C and 91900-C:	A 000		
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:	A 013	Plan of Correction is attached [handwritten, signature]	

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 Based on interview and record review the Program failed to provide adequate and appropriate services to meet the needs of 1 of 4 tenants reviewed (Tenant #2) reviewed. Finding follows: Record review on 7/20/20 revealed a Progress Note dated 6/3/20 describing a conversation between Tenant #2 and the Manager. According to the note Tenant #2 voiced concern she had not been evacuated when the fire alarm had sounded. She had seen other tenants being evauated from the building. The Manager explained that staff initially started evacuation procedures but once the fire department arrived and declared there was no fire, tenants were allowed to re-enter the building. When questioned about evacuation plans in the event of a fire, the Clinical Quality Manager sent an email on 7/16/20 at 3:09 p.m. explaining service plans specified each tenants preference regarding assistance with evacuation. This information was included on a list and the Program conducted a head count to ensure all tenants had been evacuated. Record review on 7/20/20 revealed Tenant #2's service plan indicated the tenant preferred verbal notification for evacuation. Further review revealed policies dated 12/19 documented "resident assessments indicate their ability to evacuate to a place of refuge. Offer assistance to resident listed as needing verbal or physical assistance..." A policy titled Resident Responsibilities included the following: if the residents hear the fire alarm, they should stay in the apartment, leave the door closed and unlocked, wait by the door for further instructions	A 013		

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A 013	Continued From page 2 from a staff member and when a staff member knocks on their door, follow their instruction.	A 013		
A 230	481-69.32(4) Life Safety 481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements. 69.32(4) A program serving a person(s) with cognitive disorder or dementia shall have: a. Written procedures regarding alarm systems, if an alarm system is in place. b. Written procedures regarding appropriate staff response when a tenant ' s service plan indicates a risk of elopement or when a tenant exhibits wandering behavior. c. Written procedures regarding appropriate staff response if a tenant with cognitive disorder or dementia is missing. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the Program failed to have a policy/procedure for the alarm system affecting 1 of 1 tenants identified in self-reported incident 91390 -I (Tenant #1). Finding follows: Record review on 7/15/20 revealed an Incident Report (IR) for Tenant #1. According to the IR on 7/9/20 at 7:30 a.m. Resident Assistant (RA) A went into Tenant #1's apartment but Tenant #1 could not be located. The Police contacted the Program and returned Tenant #1 at 7:45 a.m. The Program Nurse completed a head to toe assessment with no injuries noted. A progress note for this incident indicated the building and exit doors were checked when the tenant could	A 230		

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COURTYARD ESTATES AT HAWTHORNE CRO!	**601 HAWTHORNE CROSSING DR. SE BONDURANT, IA 50035**

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A 230	Continued From page 3 not be located at 7:30 a.m. Tenant #1 wore jeans, a long sleeve button down shirt. A head to toe assessment completed and noted no injuries. Tenant #1 showed the Program Nurse how he exited door S1 and climbed over the secured fence. According to the state climatologist the temperature on 7/9/20 measured 78 degrees Fahrenheit with no reported heat index. When interviewed on 7/15/20 at 11:15 a.m. RA A said she did not hear the door alarm but did note that Tenant #1 was not in his apartment. She said she checked on Tenant #1 around 7:00 a.m. and he was in his apartment but when she checked at 7:30 a.m. he was not in the apartment. She started a search of the building and called 911. According to RA A she had not noticed Tenant #1 trying to exit the building prior to this incident. When interviewed on 7/15/20 the Clinical Director of Quality said the Program had experienced a power surge and felt like the alarm not functioning most likely could be attributed to that. She confirmed the Program had no policy for documenting door alarm checks to ensure they functioned properly on a regular basis.	A 230		

Courtyard Estates Hawthorne Crossing
601 Hawthorne Crossing Dr SE
Bondurant, Iowa 50035

√ 10/29/20

Date: 8/24/2020

Complaint Intake #: Complaint 91390-C & Incident 91900-I

Plan of Correction (POC) Submitted For:

- Investigation Date: between 7/14/20 and 8/5/20
- Monitors: [redacted]

POC:

A. ***Incident 91900-Structural/Life Safety*: 69.32(4)a 481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements. 69.32(4) A program serving a person(s) with cognitive disorder or dementia shall have: a. Written procedures regarding alarm systems, if an alarm system is in place.**

   a. **Regulatory Insufficiency**: Based on observations, interview and record review the Program failed to develop written procedures regarding alarm systems. The Program admitted there was not a policy/procedure to ensure the door alarms were regularly checked and functioned properly

      i. **Program POC:**

         1. Elements detailing how insufficiency was corrected for residents:
            a. Community has implemented routine procedures regarding regular checking of door alarms.
         2. Actions program taking to protect tenants in similar situations:
            a. 7/17/2020 the community implemented door checks at shift change to monitor that alarms are functioning.
            b. 7/24/2020 The mag lock was replaced on the South Memory Care door
         3. Measures taken to ensure problem does not recur:
            a. Maintenance Coordinator or other designated person will monitor all exit doors in the community daily to ensure door alarms are functioning.
         4. Program plans to monitor performance to ensure compliance:
            a. Manager or designee will monitor documentation of door alarm checks, weekly, monthly or as determined by the manager.
            b. Regional Operations Manager and Nurse Clinician will verify during QA audits of the Program.

10/22/20

B. ***Tenant Rights*:**

a. **Regulatory Insufficiency:** When the fire alarm system sounded the Program failed to verbally notify a tenant to evacuate as indicated in the tenant's service plan.

i. **Program POC:**

1. Elements detailing how insufficiency was corrected for residents:
    a. Training for all staff on the evacuation procedures and helping residents either verbally or physically during such evacuation has been completed.
    b. Reviewing Tenant Rights during staff in-service training will be done in September 2020.
2. Actions program taking to protect tenants in similar situations:
    a. During fire or disaster drills, The Program will ensure that staff are following all ISP notifications whether it is verbal or physical or other.
    b. The nurse will ensure that all ISP's and evacuation preferences are up to date o/n the residents living in the community-completed 8/20/2020
3. Measures taken to ensure problem does not recur:
    a. During resident council meetings and mock drills the entire evacuation process will be reviewed with residents and staff and the expectations of when to stay in place and when to move to another area for evacaution. September 2020
4. Program plans to monitor performance to ensure solutions are permanent:
    a. Manager and/or designee will monitor the mock drills and ISP documentation to ensure compliance. September 2020, and ongoing as determined by the 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.