8/19/16 cac 8/19/16

PRINTED: 08/15/2016
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
	S0296	A. BUILDING: _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWATER ASSISTED LIVING	9250 EDGELINE DRIVE WEST DES MOINES, IA 50266

(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: 25 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 25 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 5 Number of tenants with cognitive disorder: 10 Total Population of Program at time of on-site: 15 TOTAL census of Assisted Living Program: 40 The following regulatory insufficiency was cited during the investigation of Incident #60684-I:	A 000	See attached POC 6/15/16	
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program ' s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on interviews and review of documentation	A 003		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Janet Simpson	Executive Director	8-18-2016

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
	S0296	A. BUILDING: _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWATER ASSISTED LIVING	9250 EDGELINE DRIVE WEST DES MOINES, IA 50266

(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 003	Continued From page 1 the Program failed to follow policies/processes for elopement. Finding follows: 1. Tenant #1, 75 years old, was admitted on 11-19-14 and diagnoses included: Alzheimer's, anxiety, depression and anemia. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. An Incident/Accident Report dated 6/6/16 stated Tenant #1 left the memory care unit at approximately 7:52 p.m. According to review of security camera footage the Program determined Tenant #1 left the memory care unit and walked to the concierge desk arriving there at 7:49 p.m. Prior to the elopement, Tenant #1 wandered around the memory care and was seen by staff at approximately 7:46 p.m. Staff heard the alarm, but since staff completed a head count prior to the alarm and noted everyone present, staff did not conduct a visual head count when the alarm sounded. Tenant #1 returned to the memory care unit at 7:53 p.m. where his/her vitals signs were taken, he/she conversed with another tenant and went to bed shortly after 10:00 p.m. The Program's Elopement risk/elopement (missing resident) Process, revised 12/23/13, included the following information under the heading when the door alarm sounds: "Check the exit door for any exiting resident by means of a visual check. Visual check means observing the area around the exit, and may require leaving the building." When interviewed on 8-3-16 the the Director of Assisted Living confirmed staff did not complete a head count/visual check when the alarm sounded as directed by the elopement process.	A 003		

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
	S0296	A. BUILDING: _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWATER ASSISTED LIVING	9250 EDGELINE DRIVE WEST DES MOINES, IA 50266

(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

CAC 8/19/16 8/19/16

Edgewater
A WESLEYLIFE COMMUNITY

9225 Cascade Avenue
West Des Moines, Iowa 50266
Phone: (515) 978-2432 Fax: (515) 978-2436

Date: August 18, 2016

Plan of Correction (POC) Submitted For:

- Self Report Investigation #60684-I on August 3&4, 2016
- Monitor: Representative of the Department

POC: 481-67.2 Program policies and procedures

A.

a.Regulatory Insufficiency:

481-67.29231B,231C231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.
This REQUIREMENT is not met as evidenced by: Based on interviews and review of documentation the Program failed to follow policies/processes for elopement.

i. **Program POC:**

1. Elements detailing how the program will correct the insufficiency as it relates to the tenant:

   a. All team members on duty at the time of the incident have been provided formal coaching and re-education of the elopement policy and procedure. The team member that did not respond to the alarm has been permanently reassigned to work in a non-memory area of the Program.

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

   a. All teams members have been provided re-education on elopement or missing person policy and procedures on June 7, 2016 by the Program nurse.

3. Measures taken to ensure problem does not recur:

    a. The Director of Maintenance and/or designee will perform monthly elopement drills and follow-up education as appropriate.

Edgewater denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy 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 provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. All measures were completed on or before June 15, 2016.