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
	S0179	A. BUILDING _____ B. WING _____	C 08/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK APARTMENTS	810 EAST VAN BUREN LENOX, IA 50851

(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: 27 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 31 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 5 TOTAL census of Assisted Living Program: 36 The following regulatory insufficiencies were cited during the investigation of Incident #62103-I:	A 000	See attached Plan of Correction POC 8/31/16	
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.	A 003		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 003	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program did not follow its policy on elopement. One tenant was identified as eloping from the Program. Tenant #1 was fitted with a wander guard to signal a door alarm when Tenant #1 was close to an exit door. Findings include: Tenant #1, an 88 year-old, was admitted on 5-10-16 with diagnoses of dementia with lewy bodies, depressive disorder, atherosclerotic heart disease, and Parkinson's disease. Tenant #1 was staged at four on the global deterioration scale which indicated moderate cognitive decline. Tenant #1 resided in the general population section of the Program. The Program reported on 8-7-16 Tenant #1 exited the building at approximately 12:50 p.m. and was found outside at approximately 1:15 p.m. when a staff member saw Tenant #1 through the window. An incident report and an internal investigation were completed. The investigation revealed there was no evidence the tenant ever left the grounds of the building. The internal investigation revealed Tenant #1 was last seen at lunch until approximately 12:30-12:45 p.m. on 8-7-16. A review of door alarm records revealed the alarm was triggered at 12:51 p.m. and the alarm was reset within a minute. The door alarm records also showed the alarm was triggered at 1:17 p.m. when Tenant #1 was returned to the building. Tenant #1 was dressed for the weather and had no signs of injury following the elopement.	A 003		

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A 003	Continued From page 2 The Manager was interviewed on 8-15-16 and stated two tenants, including Tenant #1, were fitted with a wanderguard. The nurse on duty thought the other tenant had returned to the building following an outing, and did not check on tenants in the building and did not check the outside of the building. The Manager stated the procedure for elopement was not followed. A review of the elopement policy states if an alarm sounds, alarms were to be checked promptly. The inside and outside areas triggered by the alarm were to be checked thoroughly.	A 003		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview, and a review of the clinical record, the service plan did include all specific service needs for Tenant #1. Findings include: 1. Tenant #1, an 88 year-old, was admitted on 5-10-16 with diagnoses of dementia with lewy bodies, depressive disorder, atherosclerotic heart	A 083		

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A 083	Continued From page 3 disease, and Parkinson's disease. Tenant #1 was staged at four on the global deterioration scale which indicated moderate cognitive decline. Tenant #1 resided in the general population section of the Program. Progress notes dated 6-8-16, 6-16-16, and 6-25-16 documented Tenant #1 went outside. A care conference was held with staff and family on 6-27-16 to discuss Tenant #1 leaving or attempting to leave the building "several times in recent weeks." The notes of the care conference identified Tenant #1 wore a wanderguard pendant, was checked on every 30 minutes, and had been asked to eat meals in the dementia unit. It was also noted that Tenant #1 responded better to "lets go do..." than "do you want to..." when asked about participation in activities. Tenant #1 liked to help with chores. A daily activity plan was put on a clipboard in Tenant #1's apartment. When interviewed Staff A, a Universal Worker (UW), stated when Tenant #1 was seen wandering, he/she was to be engaged in activities. Tenant #1 was taken to the dementia unit for activities. Staff A also reported Tenant #1 was incontinent and hourly checks and reminders to toilet were provided. The incontinence brief was changed if necessary. When interviewed Staff B, a UW, stated Tenant #1 was on 30 minute checks and that included a toileting schedule. A review of the service plan most recently updated on 8-4-16 identified Tenant #1 was unable to make needs understood. The service	A 083		

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A 083	Continued From page 4 plan did not identify interventions for communication. The service plan identified Tenant #1 was incontinent of bladder but did not identify interventions for incontinence including the use of incontinence briefs, a toileting schedule, and an approach for toileting such as reminding or taking Tenant #1 to the restroom. The service plan identified Tenant #1 was on 30-minute visual checks for elopement risk, but did not identify cues to possible elopement such as wandering, the approach of "lets go" rather than "do you want to", interventions such as taking Tenant #1 to the dementia unit for meals, or include the use of the daily activity plan including chores as identified in the care conference.	A 083		

9/8/16

Vintage Park Apartments
810 E Van Buren
Lenox, Iowa 50851

Date: August 31, 2016

Complaint Intake # 61203-I

Plan of Correction (POC) Submitted For:

- Investigation Date: 8/15/2016

POC:

A. ***Regulatory Insufficiency: A 003 481-67.2 \Program Policies and Procedures "Program 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."***

Program POC:

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1. Elements detailing how insufficiency was corrected for residents:

A staff in-service was held on 8/12/16 and staff were educated on the Elopement Policy. A role-play was done allowing staff to practice following the policy and the Manager and Health Care Coordinator to observe staff putting the procedure into practice. One on one education on the Elopement Policy was provided to staff not able to attend the in-service training by the Community Manager. All staff have been re-trained as of 8/26/16.

An internal investigation revealed that a staff member failed to follow the Elopement Policy during the incident occurring on 8/7/2016. Personnel action was taken due to the nature, and severity of the incident.

2. Measures taken to ensure problem does not recur:

Elopement Policy training will be completed within the first 30 days of hire for all new employees and will be put on the annual in-service training schedule.

Current employees were all trained as of 8/26/16.

R.G (Tenant #1) was moved to the secure Memory Care Unit on 8/17/2016. He continues to wear the Wanderguard bracelet and remains on 30 minute visual checks during waking hours.

3. How the Program plans to monitor performance to ensure compliance:

New staff will be trained on the Elopement Policy as a part of the Nurse Delegation process completed within 30 days of hire.

Wanderguard (Sentry System) response times will continue to be reviewed on a regular basis by the Program Manager. Staff not responding to the Wanderguard alarms in a timely manner will be counseled by the Health Care Coordinator and/or the Program Manager. These counseling sessions will be documented in the employee's file.

4. Date by which the regulatory insufficiency will be corrected:

Elopement Policy education completed on 8/26/16.

New Health Care Coordinator named as of 8/10/16.

R.G. (Tenant #1) moved to secure Memory Care on 8/17/16.

B. ***Regulatory Insufficiency: A 083 481-69.26 (1) Service Plans***
"A service plan shall be developed for each tenant based on the evaluations conducted in accordance with sub-rules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed."

Program POC:

1. Elements detailing how the program will correct each regulatory insufficiency:

The Service Plan for Tenant #1 (R.G.) was revised as of 8/17/16.

Specific interventions for communication, incontinence, visual checks, elopement cues, directives vs questions, visual checks, and daily activities are included in the revised Service Plan.

2. Measures taken to ensure the problem does not recur:

The Health Care Coordinator reviewed Iowa Code 481-69.26 regarding Service Plans along with the Program Policy regarding Service Plans on 8/31/16.

Service Plans for new tenants entering the program will be developed based on the evaluations conducted and designed to meet the specific service needs of the individual tenant as of 8/31/16.

Service Plans will be updated at least annually and whenever changes are needed. Service Plans will be reviewed at these times to ensure they are designed to meet the specific service needs of the individual tenant. (Measures on-going).

3. How the program plans to monitor performance to ensure compliance:

Service Plans for new tenants entering the program will be developed based on the evaluations conducted and designed to meet the specific service needs of the individual tenant as of 8/31/16.

Service Plans will be updated at least annually and whenever changes are needed. Service Plans will be reviewed at these times to ensure they are designed to meet the specific service needs of the individual tenant. (Measures on-going).

4. The date by which the regulatory insufficiency will be corrected:

The Service Plan for Tenant #1 (R.G.) has been revised as of 8/17/16.

The Health Care Coordinator reviewed Iowa Code 481-69.26 regarding Service Plans along with the Program Policy regarding Service Plans on 8/31/16 to ensure that Service Plans for all tenants are designed to meet the specific service needs of the individual tenant.

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.