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
	S0086	A. BUILDING: _____ B. WING _____	C 02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD PLACE	2907 S 6TH ST MARSHALLTOWN, IA 50158

(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 type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 57 Number of tenants with cognitive disorder: 20 TOTAL census of Assisted Living Program for People with Dementia: 77 The following regulatory insufficiencies were cited during the investigation of Incident #114336-I.	A 000	See Attached POC 4/30/24	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow its door alarm policy. This pertained to 1 of 1 tenants reviewed as a result of Incident #114336-I (Tenant #1). Finding follows: Record review on 2/20/24 of Tenant #1's file revealed she resided in the locked memory care unit and had a diagnosis of Alzheimer's. The Global Deterioration Scale noted a score of 4 which indicated moderate cognitive decline. Her service plan dated 6/23/23 revealed she required hourly safety checks. When interviewed on 2/19/24 at 3:33 p.m. Staff A said she worked in the memory care unit on 7/5/23 and heard the backdoor alarm go off around 7:00 p.m. She went to the door, looked	A 150		

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A 150	Continued From page 1	A 150		

out the window, and did not see anyone so she went back to what she was doing. She reported a sidewalk was located at this door that went around the back, to the side, and front of the building. She confirmed she failed to follow the Program's policy.

When interviewed on 2/19/24 at 4:08 p.m. Staff B stated she walked out the kitchen door to leave for the evening after 7:00 p.m. and saw Tenant #1 walking on the sidewalk by the front parking lot. She asked Tenant #1 to walk with her back inside and met Staff C at the front door. She reported Tenant #1 wore clothing appropriate for the weather.

When interviewed on 2/19/24 at 4:28 p.m. Staff C said she worked in the front of the building and went to the front door to clear the alarm as people were coming and going. She said Staff B walked in with Tenant #1 and said she found her outside. Staff C confirmed Tenant #1 resided in the locked memory care unit. Tenant #1 did not sustain any injuries during the incident.

According to the state climatologist the weather in Marshalltown on 7/5/23 around 7:00 p.m. was 77 degrees Fahrenheit with relative humidity of 55%. The winds were out of the NNW at 15 mph and no precipitation.

The Program was located in a residential neighborhood with a pond adjacent to the property.

The Program's Door Alarm Response Policy revealed staff were to look inside and outside the door that alarmed. The alarm could be reset after knowing who exited the door.

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A 150	Continued From page 2 The Program completed an internal investigation on 7/6/23 and determined staff failed to follow the policies for door response and resulted in an elopement and allowed Tenant #1 to be outside unattended for approximately seven minutes. On 2/20/24 at 10:38 a.m. the Director confirmed these findings.	A 150		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to evaluate the functional, cognitive, and health status as warranted. This pertained to 1 of 1 tenants reviewed as a result of Incident #114336-I (Tenant #1). Finding follows: Record review on 2/20/24 of Tenant #1's Progress Notes revealed the following entries:	A 145		

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A 145	Continued From page 3 a. 5/12/23 noted a decrease in cognition and overall health status and the family requested an evaluation from hospice. b. 6/21/23 revealed cognitive changes with increased paranoia and difficulty taking her medications. c. 7/5/23 documented Staff B found Tenant #1 outside the building and brought her back inside. Tenant #1 reported she was trying to escape the poisonous gas. No injuries were noted. No functional, cognitive, and health assessments could be located for this change in services. On 2/20/24 at 10:38 a.m. the Director confirmed these findings.	A 145		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans to reflect the individual needs of the tenants. This pertained to 1 of 1 tenants reviewed as a result of Incident #114336-I (Tenant #1). Finding follows: Record review on 2/20/24 of Tenant #1's Progress Notes revealed the following entries: a. 5/12/23 noted a decrease in cognition and	A 395		

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A 395	Continued From page 4 overall health status and the family requested an evaluation from hospice. b. 6/21/23 revealed cognitive changes with increased paranoia and difficulty taking her medications. c. 7/5/23 documented Staff B found Tenant #1 outside the building and brought her back inside. Tenant #1 reported she was trying to escape the poisonous gas. d. 7/26/23 reviewed ongoing paranoid behaviors of thinking someone was trying to poison her with gas and putting blankets under her door and window. She required multiple attempts by staff to administer medications and provide meals. Tenant #1's Service Plans dated September 2023 failed to include the assistance required to minimize exit seeking and paranoid behavior. On 2/20/24 at 10:38 a.m. the Director confirmed these findings.	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S0086	DATE SURVEY COMPLETED: 2/20/2024

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Tag #1	**Regulation and Reg Number 481-67.2(3) Program Policies and Procedures 67.2(3)** The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow its door alarm policy. This pertained to 1 of 1 tenants reviewed as a result of Incident #114336-I (Tenant #1).	**Tag # A150**	**What initial correction was made?** Education provided to staff regarding Elopement Policy and checking of door alarms procedures on 7/6/2023. Staff who did not follow policy and procedure related to door alarm response were provided individual counseling on 7/5/2023	**How will we ensure and maintain compliance going forward?** Upon hire and annually, staff training will be completed on missing person policy and door alarm response policies. Quarterly elopement drills are completed to monitor staff response to a missing resident. Monthly, Quarterly as determined by the Director or designee monitoring of staff response to door alarms is being completed.	**Implementation Date:** 7/6/2023 **Completion Date:** Ongoing **Responsible Party:** Director or Designee

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.

Tag #2	**Regulation and Reg Number 481-69.22(3) Evaluation of Tenant 69.22(3)** Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to evaluate the functional, cognitive, and health status as warranted. This pertained to 1 of 1 tenants reviewed as	**Tag # A145**	**What initial correction was made?** Service Plans will be individualized for residents and behaviors, refusals, or pther significant changes will be identified on the resident's service plans. Staff AK is no longer employed at Glenwood Place as of 7/7/2023. Staff HB is no longer employed by Glenwood Place as of 10/6/2023 New HCC was hired on 8/21/2023 New AHCC was hired on 11/13/2023 Tenant #1 had an evaluation completed including functional, cognitive and health status on 12/19/2023.	**How will we ensure and maintain compliance going forward?** New Nurses were trained in individualization of service plans for each resident, addressing their needs and requests, along with services being provided. The Director or designee will audit monthly, and as needed, as determined by the director or designee to ensure completion.	**Implementation Date:** 7/7/2023 **Completion Date:** Ongoing **Responsible Party:** Director or Designee

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	a result of Incident #114336-I (Tenant #1).				
Tag# 3	**Regulation and Reg Number 481-69.26(4)a Service Plans 69.26(4)** The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans to reflect the individual needs of the tenants. This pertained to 1 of 1 tenants reviewed as a result of Incident #114336-I (Tenant #1).	**Tag# A395**	**What initial correction was made?** Service Plans will be individualized for residents and any behaviors, refusal, or changes will be identified on the resident's specific service plans. An audit is in process for all residents to ensure needs and requests are addressed in each resident individualized service plans Staff AK is no longer employed by Glenwood Place as of 7/7/2023. Staff HB is no longer employed by Glenwood Place as of 10/6/2023 New HCC was hired on 8/19/2023 New AHCC was hired on 11/13/2023 Tenant #1's Service plan was updated on 2/22/2024.	**How will we ensure and maintain compliance going forward?** New Nurses were trained in individualization of service plans for each resident, addressing their needs and requests, along with services being provided. The Director or designee will audit monthly, and as needed, as determined by the director or designee to ensure completion.	**Implementation Date:** 7/7/2023 **Completion Date:** Ongoing **Responsible Party:** Director or Designee

Compliance Date:__4/30/2024_____

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