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
	S0117	N	C 01/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John's Harbor Memory Loss Center	3520 GRAND AVE DES MOINES, IA 50312

(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. Number of tenants without cognitive disorder: 3 Number of tenants with cognitive disorder: 13 Total census: 16	A 000	In regards to the elopement of tenant #3: All staff have been re-educated on the elopement policy and reporting guidelines. New signage has been placed to remind anyone exiting the program to make sure no one leaves with them. Other departments on campus (dining/maintenance) were reminded to not allow anyone to exit the program with them per the new signage. A wanderguard has been placed on tenant #3 and staff are checking placement on the MAR to be sure he has not removed it. In regards to the service plan of tenant #3: The service plan has been updated to include an activity plan addressing things that staff can do to address wandering and requests to leave the unit. This includes an exercise program and a wellness program. In regards to all tenants in the program: All service plans in the program were reviewed to be sure they address any elopement risks and	3/5/2021
A 025	The following regulatory insufficiencies were cited during the investigation of Complaint #94968-C. 481-67.4(4) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(4) When a tenant elopes from a program. This REQUIREMENT is not met as evidenced by: A 025 Based on interview and record review, the program failed to report 1 of 1 elopements reviewed to the Department. Findings follow: On 12/29/20 at 8:50 AM, Staff C reported Tenant #3 once followed a kitchen staff person off the unit. At 12:22 PM on 1/13/21 the RN (Registered	A 025 A083		

	Nurse) reported she had just learned of the incident that day and was investigating it. She learned Tenant #3 eloped for approximately 5 minutes on 12/21/20. Staff members present at the time said they didn't report the incident because he was gone for such a short time. Staff D and Staff E were working the floor while Staff F and Staff C were in the office. Tenant #3 was with his wife back by the office. The tenant asked Staff F and Staff C for some things he needed at the store and they told him they would let his daughter-in-law know. Tenant #3 seemed to accept this and continued on. Less than ten minutes later, Staff F received a call stating Tenant #3 needed to be picked up at Door 5 on the campus. The staff members were unsure of how he got out. They thought maybe he got behind one of the kitchen carts when kitchen staff were picking up the dishes. The RN determined all other staff knew Tenant #3 wasn't allowed to leave the unit unattended, so the staff picking up the cart must have been unfamiliar with the tenant. According to staff, the incident occurred early in the afternoon, after lunch. On 1/14/21 at 11:23 AM the RN confirmed the elopement was not reported to the Department as she was unaware of the incident until 1/13/21.		intervention. All staff have been re-educated on the elopement policy and reporting guidelines. New signage has been placed to remind anyone exiting the program to make sure no one leaves with them. Other departments on campus (dining/maintenance) were reminded to not allow anyone to exit the program with them per the new signage. FOLLOW UP: Tenants will be assessed quarterly by the program RN for wandering and elopements. If the tenant is identified as having wandering or elopement behaviors, it will be noted on the service plan along with interventions staff can try. A program RN will review this quarterly and with any significant change in condition. Wanderguard placement checks have been added to the MAR for tenants that use wanderguards. This will be documented by staff each day to be sure wanderguards have not been removed. The program RN will check this documentation quarterly to see that it is being completed.	
A083	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 record review the program failed to ensure service plans were updated when changes occurred for 1 of 3 tenants reviewed (Tenant #3). Findings follow: A review of Tenant #3's file revealed an admission date of 7/17/20. A Progress Noted dated 8/14/20 indicated he had been quite anxious the past week and wanted to leave. He got very frustrated when he was told he could not leave without an escort. His doctor was notified and he received an order for an antidepressant. On 12/31/20 at 3:30 PM, Staff A reported Tenant #3 tried to leave the memory care unit. When the tenant wanted to leave, he put his coat on and said he needed to go to the store. Staff were able to redirect the tenant when that occurred. Staff A said Tenant #3 had a Wanderguard at one time which was a device to notify staff when a tenant left the unit. On 12/31/20 at 3:50 PM, Staff B stated Tenant #3 was often agitated and wanted to go to a store called Price Chopper. She was able to redirect Tenant #3 to other tasks when he came out of his apartment in his coat and hat. On 12/29/20 at 8:50 AM, Staff C reported Tenant #3 wanted to go out to get new things. She recalled once he followed a kitchen staff person off the unit and he was known to push on an exit door. They had put a Wanderguard on Tenant #3's wrist but he kept taking it off. On 12/29/20 at 10:40 AM, Staff D reported Tenant #3 often wandered around the unit. She said he wanted to leave and go to the store. The tenant had tried to follow people off the unit. She thought he had a Wanderguard at one time but he cut it off. On 12/29/20 at 12:40 PM, Staff E stated when Tenant #3 asked to go to the store, she redirected him to another activity.			

	Wandering and interventions to assist Tenant #3 when he wanted to leave the program were not on his service plan last dated 8/6/20.			