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
	S0208	A. BUILDING: _____ B. WING _____	C 04/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF MT PLEASANT	1406 EAST LINDEN DRIVE MOUNT PLEASANT, IA 52641

(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: 36 Number of tenants with cognitive disorder: 2 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 7 TOTAL Census of Assisted Living Program for People with Dementia : 45 No regulatory insufficiencies were cited during the investigation into Complaints #98687-C and #103946-C. The following regulatory insufficiency was written during the investigation of Incident #97707-I.	A 000		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to have an operating alarm system connected to the exit door in the dementia-specific program. This pertained to 1 of 1 tenants reviewed (Tenant #1) as a result of Incident #97707-I and potentially affected all tenant in the locked memory care unit. Findings follow: Record review of Tenant #1's file on 4/18/22	A 635		

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A 635	Continued From page 1	A 635		

revealed he resided in the locked memory care unit and scored a 5 on the Global Deterioration Scale which indicated moderately severe cognitive decline. An Incident Report and Investigation Worksheet dated 6/2/21 revealed another tenant's family opened the memory care gate as they moved another tenant's belongings into the building. Tenant #1 was outside in the courtyard and walked out through the back gate to the front of the building. The Health Services Director (HSD) observed him at the front door of the community. He was assessed for injuries and none were noted. Intervention were put in place to check the gates each time to ensure they were locked.

Staff received education on elopement prevention on 6/3/21. The training included the doors to the dementia unit are to be closed and always alarmed except when a staff member is outside with the tenants. If a tenant was outside, a staff member must be with them. Staff must check both garden gates to make sure they are locked every time a tenant was in the courtyard. The gates must be checked after a vendor left to ensure they were locked.

According to the state climatologist the weather in Mt. Pleasant at 3:00 PM on 6/2/21 was partly cloudy with a high of 77 degrees.

An Incident Report and Investigation Worksheet noted on 9/2/21 noted a lawn service company did not notify the Program when they were done mowing and left the courtyard gate unlocked. A staff observed Tenant #1 walk out the gate and called for assistance to bring him back to the unit. The mowing company was told to notify staff after they were done so the gate could be locked.

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A 635	Continued From page 2 Nurse Reviews dated 3/11/21, 6/10/21 and 9/2/21 documented Tenant #1 displayed exit seeking behaviors daily. When interviewed on 4/19/22 at 2:25 p.m., Staff A confirmed a family moved items into the building for another tenant on 6/2/21 and the doors in the courtyard and memory care unit were both unsecured. The alarm to the memory care door was turned off. Staff A stated she was doing 15-minutes checks on tenants at the time and could not find Tenant #1. Staff A notified her co-workers to look for him when he showed up at the front door of the building. Tenant #1 seemed to be in good health when he returned to the memory care unit. She estimated Tenant #1 was away from the memory care unit for approximately five to seven minutes. The Executive Director and HSD confirmed these findings on 4/20/22 at 8:45 AM.	A 635		