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
	S0228	A. BUILDING: _____ B. WING _____	C 08/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW MEMORY CARE VILLAGE	3005 F AVENUE NW CEDAR RAPIDS, IA 52405

(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 impairment: 5 Number of tenants with cognitive impairment: 29 Total census: 34 No regulatory insufficiencies were cited related to the investigation of Incident #110880-I. The following regulatory insufficiencies were cited during the investigation of Incidents #110585-I and #113325-I:	A 000	The Plan of Correction is attached.	
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 observation, interview and record review the Program failed to follow established policies and procedures related to door alarms and nurse notification. This pertained to 1 of 1 current tenants reviewed who eloped (Tenant #1) and 1 of 1 discharged tenants reviewed with an attempted self-harm incident (Tenant C1). Findings follow: 1. Review of Tenant #1's file between 8/23/23 and 8/28/23 revealed an Incident Report Form dated 5/23/23 at 6:48 p.m. indicating Tenant #1 left the building via the ice cream parlor door to the courtyard. Staff A completed the report and	A 150		

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A 150	Continued From page 1	A 150		

indicated she went to the doors but did not see anyone, then went outside the kitchen door and into the parking lot and did not see anyone. The Executive Director called and told her Tenant #1 was in the courtyard. Staff A went to get Tenant #1 who was outside by the laundry door. She was wearing a red plaid shirt, black pants and brown shoes and was carrying a gray shoe. It was noted that she did not have any visible injuries and there were no concerns with her vital signs. The incident was reported to the nurse on 5/23/23 at 6:48 p.m. and Tenant #1's legal representative on 5/23/23 at 7:00 p.m. Tenant #1's primary care provider was notified on 5/24/23.

The Executive Director's written statement indicated she received a notification on her cell phone from a doorbell camera that there was motion detected in the courtyard. She called Staff A at 6:48 p.m. and informed her Tenant #1 was outside in the courtyard. Review of the camera footage indicated at 6:39 p.m. Tenant #1 walked outside into the courtyard area and the alarm sounded. Tenant #1 was brought back into the Program at 6:53 p.m. The temperature was 78 degrees and Tenant #1 was wearing a long sleeved shirt, black pants and brown slip on shoes. It was noted the courtyard was shaded and Tenant #1 did not sustain any injuries. Staff had been re-educated on the door alarm policy and missing tenant policies, the doors were labeled numerically and matched the numbers sent on the pager alerts, staff were re-educated on what door corresponded to each number, a lock had been added to the door in the courtyard and all staff had access to unlock if needed. Tenant #1 was placed on hourly checks. An alarm company had been working on the door alarms systems and a new mag lock was ordered for the door that Tenant #1 eloped from.

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A 150	Continued From page 2 When interviewed on 8/24/23 at 1:22 p.m. Staff A said while passing medications she heard an alarm go off and went to the back and looked out the windows. She walked through the parking lot but did not walk through the courtyard. She said the key pads in that area were not lit up. She walked to the kitchen door, opened it and walked outside. She did not see anyone. She went back to passing medications and received a telephone call from the Executive Director regarding a tenant in the courtyard. She went to the courtyard and observed Tenant #1 by the laundry room door. She was locked out and had to call for staff to let them back in. She did not have her walkie-talkie but had her phone. Staff A called the Director of Nursing (DON) to let her know. She directed her to take her vital signs and fill out an incident report. Tenant #1 did not have any injuries. Staff A said she was not carrying a pager at that time as there were not enough to go around. She received re-education on going out the door (to search) and using the walkie-talkie to call for assistance. She said one of her co-workers was on break and was not in the building. The other co-worker said she called on the walkie-talkie but Staff A never heard her call. Staff A's interview statement for the Program dated 5/24/23 indicated she heard the door alarm at approximately 6:30 p.m. and went to the hallway near the kitchen and parlor area. Staff A looked out both parlor doors but did not see anyone. She went to the kitchen door and out to the parking lot area but did not see anyone. She returned inside and was notified by the Executive Director that Tenant #1 was outside in the courtyard. She responded and brought Tenant #1 back into the building. Tenant #1 did not sustain any injuries.	A 150		

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A 150	Continued From page 3 When interviewed on 8/24/23 at 10:19 a.m. Staff B said she was in another tenant's apartment and received a page that indicated a door was open. She asked which door via the walkie-talkie but did not receive an answer. She stayed with the tenant she was assisting and then came out of the apartment. She was informed by Staff A that Tenant #1 had gotten outside. She said the other co-worker was on break when it occurred. Staff B's interview statement taken on 5/24/23 indicated she was helping another tenant, she did not hear the door alarm but saw the alert on the pager that indicated "door 2" was open. Staff B said she announced on the walkie-talkie that door 2 was open. When she was finished with her cares, she went towards the medication room and saw Staff A, who confirmed Tenant #1 had gotten outside. When interviewed on 8/28/23 at 9:56 a.m. the Executive Director she was at home and received a notification on her phone from the doorbell camera. She was able to see Tenant #1 outside in the courtyard. She called staff and they brought her back inside. Tenant #1 was outside for approximately 10 to 15 minutes. The DON was notified and she called Tenant #1's family. The Executive Director reviewed alarm records and the alarm and pagers went off but staff did not respond appropriately. Staff A said she heard the alarm, went and looked out the door and called it good. Staff was supposed to look everywhere and if someone was not seen to start a head count. Staff B said she was helping another tenant and Staff C1 was on break and was not in the building. Staff received re-education, the mag lock was replaced on the door (for the electronic wandering monitoring	A 150		

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A 150	Continued From page 4	A 150		

system), the doors were labeled numerically and the locking system was replaced in about two weeks. She confirmed Staff A did not follow the policy and go outside and check the area. Staff B should have kept trying to walkie other staff or respond if able.

On 8/24/23 at approximately 12:00 p.m. the area of Tenant #1's elopement was observed. The courtyard appeared to be fully enclosed by either the exterior of the building or fencing or similar type materials. There was a gate, which was locked, and two doors that went into the building, including the ice cream parlor door that Tenant #1 exited. The courtyard had a concrete sidewalk and had several places to sit throughout the area. The courtyard followed around the east side of the building and the entire courtyard was not visible when looking out of the ice cream parlor door.

On 8/24/23 at approximately 11:10 a.m. the video footage from the doorbell camera was observed. On 6:38 p.m. Tenant #1 left the building. At 6:41 p.m. and 6:45 p.m. Tenant #1 came back to the door. At 6:53 p.m. Staff A arrived to let Tenant #1 back into the building. It was noted on the video Tenant #1 was wearing a long sleeved plaid shirt, pants and footwear. The Executive Director confirmed in the review of the video that it was a motion detected camera.

Review of Tenant #1's file revealed she was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #1's service plan dated 5/22/23 (in place at the time of the elopement) indicated she was at an increased risk for elopement. It also indicated staff were to complete checks with a.m. and p.m. cares, at meals, three times overnight and as

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A 150	Continued From page 5	A 150		

needed.

Further record review revealed a Disciplinary Report Form dated 5/24/23 indicated Staff A failed to respond to a door alarm that resulted in an elopement. The policy was reviewed and staff were expected to follow the door alarm and missing tenant policies.

The Program's policy and procedure related to door alarms indicated staff was to check the system for the location of the alarm and immediately respond to that door. Staff was to go to the door, go outside and check the grounds to determine the source of the alarm. It was due to a tenant, staff was to assist the tenant inside and notify the nurse. If the source of the alarm was not found, staff was to account for all tenants. If a tenant was not located, staff was to start the missing tenant policy.

Staff did not follow the door alarm policy and procedure related to Tenant #1 elopement on 5/23/23.

2. Review of Tenant C1's file on 8/23/23 and 8/24/23 revealed an Incident Report Form dated 1/12/23 at 8:10 a.m. indicating staff found Tenant C1 in the shower with the shower head wrapped around his neck. Tenant C1 was sent out for evaluation.

The Executive Director's written statement indicated on 1/12/23 at about 8:30 a.m. she was notified by the DON that staff had found the tenant in the corner of his shower with the shower cord wrapped around his neck. Tenant C1 had been observed about 20 minutes prior sleeping in bed. Tenant C1 was taken to the hospital, no injuries were found and he returned the same

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A 150	Continued From page 6 day. Staff from the prior shift reported he had no history of suicidal thoughts prior to the incident. A Staff Communication Report dated 1/12/23 at 6:00 a.m. was completed by Staff D who worked the third shift. She indicated Tenant C1 was more disoriented and his oxygen saturation was below 90%. The document indicated it was reported to two first shift direct care staff but not to the nurse. Continued record review revealed the January 2023 medication administration records (MAR) reflected an order for oxygen per nasal cannula at 5 liters and to check oxygen saturation every shift and report to the nurse if below 90%. On 1/11/23 (night shift) it was 83% and on 1/12/23 (night shift) it was 82%. Both were signed off by Staff D on the MAR. RN Notification delegation indicated staff would notify the nurse including if a tenant had a change in behavior and if vital signs were outside of parameters. Staff did not notify the nurse as needed related to the change in behavior and oxygen saturation outside of parameters for Tenant #1, which occurred on the shift prior to staff finding him with a shower cord wrapped around his neck. When interviewed on 8/28/23 at 9:56 a.m. the Executive Director confirmed Staff D should have notified the nurse of the behavior and oxygen saturation for Tenant C1.	A 150		
A 350	481-69.26(1) 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	A 350		

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A 350	Continued From page 7	A 350		

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 update service plans when needs changed for 1 of 2 current (Tenant #1) and 1 of 2 discharged (Tenant C1) tenants reviewed. Findings follow:

1. Review of Tenant #1's file between 8/23/23 and 8/28/23 revealed an Incident Report Form dated 5/23/23 at 6:48 p.m. indicating Tenant #1 left the building via the ice cream parlor door to the courtyard. Staff A went to the doors but did not see anyone. The Executive Director called Staff A and told her a tenant was in the courtyard. When Staff A responded she found Tenant #1 by the laundry room door. Tenant #1 did not have any visible injuries related to the incident.

The Executive Director's statement indicated Tenant #1 exited the door at 6:39 p.m. and was brought back inside by staff at 6:53 p.m. Tenant #1 was placed on hourly checks. The service plan indicated to take her outside when weather was permitting.

Further record review revealed an Incident Report Form dated 5/24/23 at 6:26 p.m. indicating the door alarm sounded and the pager sent an alert and staff responded. Tenant #1 had gone out the door in the soda pop room. Tenant #1 was fully dressed and was wearing shoes. Vital signs were

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A 350	Continued From page 8 taken and the nurse was called. Tenant #1's service plan in place at the time of elopement was dated 5/22/23. The service plan reflected Tenant #1 was at increased risk for elopement. Staff were to complete checks with a.m. and p.m. cares, at meals, three times overnight and as needed. The service plan had an update that was created on 5/24/23 and revised on 5/25/23 to reflect Tenant #1 preferred to be outside and included planned activities outside weather permitting. The service plan was updated on 5/31/23 to reflect Tenant #1 had a history of elopement and had one hour safety checks. The service plan was not updated until 5/31/23, despite the elopement on 5/23/23 and the incident on 5/24/23 when Tenant #1 again left the building and set off the door alarms. 2. Review of Tenant C1's file on 8/23/23 and 8/24/23 revealed a Nurse Review dated 1/12/23 indicating staff found Tenant C1 in the dark bathroom with the shower cord wrapped around his neck. Staff removed the shower head from his neck and redirected him to sit in the recliner. Vitals were taken and Tenant C1's oxygen saturation was 82% on 5 liters of oxygen. The nurse review indicated the service plan was reviewed and would be updated for significant change as Tenant C1 had not demonstrated that behavior previously. An updated service plan reflecting the potential attempt of self-harm and any needed interventions could not be located. 3. When interviewed on 8/28/23 at 9:56 a.m. the Executive Director confirmed all service plans for the tenants listed above were provided.	A 350		

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A 370	Continued From page 9	A 370		
A 370	481-69.26(3)a Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtained signed service plans for 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Review of Tenant C1's file on 8/23/23 and 8/24/23 revealed a Health and Functional Assessment dated 1/13/23 reflecting an order was received for hospice on 1/13/23 and Tenant C1 would be admitted to hospice services on 1/14/23. A service plan was dated 1/13/23 to reflect hospice services; however, the service plan was not signed by all parties. 2. When interviewed on 8/28/23 at 9:56 a.m. the Executive Director confirmed all service plans for the tenant listed above were provided.	A 370		

Department of Inspections, Appeals, & Licensing
Attn: Deb Dixon
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Dixon:

On behalf of MeadowView Memory Care Village in Cedar Rapids, Iowa, I respectfully submit our Plan of Correction for your approval. This response is specific to the incident investigation 08/22/2023-08/28/2023. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusions set forth in the statement of insufficiencies. The Plan of Correction is executed solely because it is required by the provisions of Iowa Law.

Program Policies and Procedures

1. Elements detailing how the Program will correct each regulatory insufficiency
    - If Tenant #1 activates the door alarm, staff will follow the door alarm policy.
    - Staff will follow the door alarm policy if the door alarm is activated, including physically going outside of the door if necessary, at all times.
    - Tenant C1 no longer resides with this Program.
    - Staff will follow the delegation of When to Notify the RN.
    - Staff have been provided with written documentation forms as well as additional resources, including contact phone numbers for on call nurse after hours, to report any questions or concerns.
2. Measures taken to ensure the problem does not recur
    - All staff were re-educated on the door alarm policy as of 6/8/23 and 10/18/23.
    - All staff were re-educated on When to Notify the RN as of 10/18/23.
    - All staff were re-educated on Staff Communication report as of 10/18/23.
3. How the Program plans to monitor performance to ensure compliance
    - The Executive Director and/or Designee will ensure all staff are educated on the Door Alarm policy upon hire.
    - The Director of Nursing and/or Nurse Designee will ensure staff are educated on When to Notify the RN upon hire.
    - The Executive Director will ensure staff are provided ongoing training on the Door Alarm policy via elopement drills at least annually.
    - The Director of Nursing and/or Nurse Designee will ensure staff are provided ongoing education on When to Notify the RN at least annually and/or as need arises.

4. Date by which the Regulatory Insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before November 5, 2023.

Service Plans

1. Elements detailing how the Program will correct each regulatory insufficiency
    - Tenant #1 will have timely updates to her service plan when needs change per regulation.
    - Tenant #C1 no longer resides in the Program.
2. Measures taken to ensure the problem does not recur
    - The Director of Nursing and Nurse Designees will be re-educated on updating service plans when needs change per Iowa Code 481-69.26(1), 69.22(1), 69.22(2).
    - The Director of Nursing and Nurse Designees will be re-educated to develop an individualized service plan for each tenant.
    - Service Plans will be developed for each tenant based on the evaluation completed and individualized to meet the tenant's specific needs and updated at least annually.
3. How the Program plans to monitor performance to ensure compliance
    - The Director of Nursing and/or Nurse Designee will audit tenant service plans at least quarterly to ensure compliance with regulatory requirements.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before November 5, 2023.

Service Plans- Signatures

1. Elements detailing how the Program will correct each regulatory insufficiency
    - Tenant C1 no longer resides within this Program.
    - If a significant change triggers the review and update of the service plan, the updated service plan will be signed and dated by the Nurse who completed the assessment and service plan updates as well as the tenant and/or POA as applicable per regulations.
2. Measures taken to ensure the problem does not recur
    - Re-education will be provided to the Director of Nursing and Assistant Director of Nursing regarding 481-69.26(3)a Service Plans.
    - Program established process for obtaining signatures from POA for Cognitively Impaired tenants including scheduled follow ups at weekly intervals monitored by Front Desk staff to ensure timely signature.
3. How the Program plans to monitor performance to ensure compliance
    - The Director of Nursing and/or Nurse Designee will audit charts at least quarterly to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before November 5, 2023.

Executive Director