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
	S0261	A. BUILDING: _____ B. WING _____	C 03/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD ESTATES AT HAWTHORNE CROSSING	601 HAWTHORNE CROSSING DR. SE BONDURANT, IA 50035

(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. General Population Program Number of tenants without cognitive disorder: 18 Number of tenants with cognitive disorder: 2 Memory Care Unit Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 9 TOTAL census of Assisted Living Program for People with Dementia: 31 The following insufficiencies were cited during the investigation of Incident #101735-M, Complaints #101714-A, #101794-A, and #102066-C. No regulatory insufficiencies were cited during the investigation of Complaints #99434-C, #100071-C, #100496-C, and #100553-C.	A 000	POC attached ok 5-4-22	
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 it's policies and procedures as established for 2 of 9 discharged tenants reviewed (Tenant #C1 and Tenant #C2). Findings follow:	A 150		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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1. Record review of Tenant #C1's file on 1-25-22 revealed the following:

Incident Report dated 1-21-22 revealed at approximately 6:19 a.m. the Registered Nurse (RN) received a call from Staff B who reported Tenant #C1 was found outside of the East Garden Door in the memory care unit. Staff brought her inside and covered her with blankets and immediately called 911. They reported she failed to respond but then found a pulse. Emergency services arrived and transported Tenant #C1 to the hospital. Around 8:55 a.m. the Sheriff arrived to investigate and informed the Program Tenant #C1 passed away at the hospital. Staff noted she wore long pants, a sweater, and shoes with the temperature noted to be around 7 degrees below zero.

The Service Plan dated 11-13-21 revealed she required assistance with activities, bathing, toileting, medications, and received hospice services. Continued review noted forgetfulness, mild to moderate disorientation, difficulty retaining information, wore a wanderguard for added safety, and required hourly safety checks. Further review revealed diagnoses of Alzheimer's disease, major depressive disorder, and anxiety disorder.

The Global Deterioration Scale completed 8-13-21 revealed a score of 5 and indicated moderately severe cognitive decline.

A 90 Day Review dated 11-13-21 revealed she continued to have episodes of anxiety, packed up her room, and attempted to leave the community. She exit seeked and wandered at times of high anxiety and had PRN (as needed) medications to assist with behavior and had been effective. A

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A 150	Continued From page 2 Century System had been placed on her apartment door to assist with monitoring and had been effective this quarter with no elopements. 2. Documents and surveillance video provided by the Program confirmed the following: Documentation Survey Reports revealed Staff A failed to complete and document hourly safety checks on December 28, 2021 at 10:00 p.m. until December 29, 2021 at 6 a.m., December 29, 2021 at 10:00 p.m. until December 30, 2021 at 6 a.m, and January 20, 2022 at 10:00 p.m. until January 21, 2022 at 6 a.m. Device Activity Report revealed E5 East Garden Door alarmed at 9:34 p.m. on 1-20-22 until cleared at 6:12 a.m. on 1-21-22. Tenant #C1's door alarmed at 4:23 p.m. on 1-20-22 until cleared at 7:15 a.m. on 1-21-22. On 1-20-22 video footage recorded Staff A arriving after 10 p.m. Continued review showed her walking around the unit from approximately 11:09 p.m. until 2:44 a.m. and failed to walk down the east hallway to complete safety checks. A male tenant walked around the unit and appeared to fall asleep in a chair. Further review revealed around 2:44 a.m. until 6:10 a.m. she continued to walk around the memory care unit. She walked over to the assisted living area two times, and walked past the sleeping male tenant several times. She failed to walk down the east hallway throughout the night to complete hourly checks as required. 3. Record review of the hospital's emergency room documentation revealed Tenant #C1 arrived at 7:23 a.m. on 1-21-22. The Pre-Arrival Summary noted the chief complaint to be	A 150		

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"hypothermia, cold, stiff, ice freezing on her, responsive to pain, head and hand abrasion". Further review revealed en route her pulse was 40 beats per minute and when pulse was lost, EMS (Emergence Medical Services) performed CPR for approximately 90 seconds. Upon arrival at the hospital, EMS noted a slight pulse and when brought in to the emergency room, no pulse could be obtained. EMS stated she was too cold to obtain a temperature. Continued review revealed her temperature to be around 25 degrees Celsius (77 degrees Fahrenheit). Family was contacted and determined efforts to be ceased due to lack of expected meaningful recovery. The diagnosis was cardiac arrest and hypothermia and Tenant #C1 was deceased.

4. Record review of Polk County Medical Examiners Report of Autopsy documented pathologic diagnoses included heart failure and hypothermia due to cold exposure. Tenant #1's cause of death was documented as hypothermia (minutes) due to environmental cold exposure (hours) and the manner of death was documented as an accident.

5. According to the state climatologist the weather in Bondurant on 1-20-22 around 6:19 a.m. was -11 degrees Fahrenheit with relative humidity of 76%, the sky was clear, and the wind was calm with no windchill.

6. Record review on 2-7-22 of Tenant #C2's Service Plan dated 11-2-21 revealed she required 24 hour supervision and hourly safety checks. Review of Documentation Survey Report revealed Staff A failed to complete and document hourly safety checks from December 21, 2021 at 10:00 p.m. until December 21, 2022 at 6 a.m.

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A 150	Continued From page 4 7. Record review on 1-31-22 of the Program's policy and procedures and job descriptions confirmed the following: The Elopement Policy stated routine visual checks would be completed on tenants with confusion at or above Stage 4 on the Global Deterioration Scale. For tenants at risk of wandering, a Sentry System may be installed in individual apartments. If a tenant exited their apartment an emergency call would be activated to notify staff to check on the tenant. The system included visual checks eight times per shift. Staff were to watch for signs of wandering and confusion that may put the tenant at risk of elopement and if an exit door alarm sounds they should thoroughly check inside and outside areas triggered by the alarm. Nurse Delegation for Visual Checks required staff to enter the apartment and make visual contact of tenant, document visual check in Point of Care/Companion according to scheduled time to ensure tenant safety. If staff failed to see the tenant they were required to check the building until the tenant was located. Staff were required to ensure they completed all required documentation on all tenants. Nurse Delegation for Door Alarm Response revealed as staff received a notification to their IPAD of a door breached or opened, staff should immediately go to that door and observe inside and outside that door to find out who utilized the door. After knowing who used the door staff could push the green button, enter the code, on IPAD, etc to reset the door. The procedure included the alarms were in place to keep tenants safe. Ex. If a tenant exhibited increased confusion they may exit the community in inclement weather without	A 150		

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A 150	Continued From page 5 being properly clothed. Nurse Delegation for Point of Care, EMAR or Companion revealed staff logged into program with individualized and confidential login information. Staff selected the specific program for correct documentation and review required tasks. Staff logged out after ensuring all tasks had been completed to prevent use from an unauthorized person. Community Manager job summary revealed the Director is on call 24/7 and maintained normal business hours 8 a.m. to 5 p.m. Monday through Friday. The Director's role included to ensure resources were in place to deliver quality essential services, to assure quality workmanship and performance was achieved by on-site staff. Continued review revealed Operational and Emergency Monitoring included to assure 24/7 coverage to carry on daily operational services and needs. Healthcare Coordinator Essential Functions included to coordinate and implement the delivery of tenant care and to assure 24/7 coverage to respond to calls for urgent assistance from tenants of the Community, respond to fire alarms or other emergencies, and other duties as assigned. 8. Record review of staff files on 1-31-22 revealed the following: Staff A signed the Elopement Policy on 6-9-21, the Nurse Delegation for Door Alarm Response, Visual Checks, and Point of Care delegations on 11-22-21, and acknowledged she was competent to complete the task as trained. On 1-3-22 she received a verbal warning over the phone from	A 150		

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the LPN for failure to document tasks performed on her shift in Point Click Care on 12-30-21 as required. Corrective action included timely charting during her shift to reflect the cares provided to the tenants. On 1-28-22 the Program mailed a letter of termination effective 1-21-22.

Staff B signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-21-22 she received a written warning for failure to respond to door alarms as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants.

Staff C signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-21-22 she received a written warning for failure to respond to door alarms as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants.

Staff D signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-25-22 she received a written warning for failure to respond to door alarms and failure to carry an IPAD as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants.

Staff E signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-25-22 she received a written warning for failure to respond to door

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alarms and failure to carry an IPAD as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants.

9. Staff interviews revealed the following:

On 2-1-22 at 11:30 a.m. Staff A revealed the following:
She started about six months ago and confirmed the Program provided training for safety checks and door alarms. Two staff usually worked in the memory care unit overnight and on 1-20-22 she was the only staff and Staff B worked in the assisted living area. She stated a male tenant yelled, banged, and attempted to exit the memory care unit at times that kept her busy throughout the entire shift. He wasn't wearing a jacket and required constant supervision to prevent him from going outside the door in the lounge area for most of her shift.

Her IPAD was in the TV room and another IPAD was in the laundry room. The door alerts failed to appear on either IPAD. She provided a screen shot that revealed she texted the Executive Director in December 2021 the door alarm failed to show up on her tablet.

Around 4 or 5 in the morning Staff B arrived and stated the computer showed the door alarm going off. She dropped everything, searched the area,and found Tenant #C1 outside the exit door in the East Hallway. Both staff brought her in and covered her with blankets and immediately called 911. She observed clothing hung and draped on the handrail and a purse near Tenant #C1.

She confirmed knowledge of the camera located in the lounge above the exit door that recorded 24

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hours per day and continued to state she worked on laundry and provided supervision to the male tenant throughout her shift. She confirmed Tenant #C1 required an alarm on her apartment door because "she can leave and had a history of doing it" and stated "it is very important to check and make sure they are safe". The previous staff informed her everyone was ok and tenants were in their rooms and did not see Tenant #C1 at this time. She observed Tenant #C1's door was shut and failed to explain how she knew the door was shut when the video revealed she never walked down Tenant #C1's hallway. She failed to do rounds to check each tenant hourly as trained and continued to insist the male tenant required her full attention for the entire shift and prioritized keeping him from exiting the building.

This surveyor explained the video failed to match how she described her shift and revealed the male tenant asleep around 2:53. She stated she remained in the TV room from 3:32 am to 5:23 a.m. and peaked her head out to make sure he was ok. She prioritized monitoring the male tenant because the door alarms failed to show up on the tablet at times. She stated it "slipped my mind to do safety checks" down the east hallway. She checked on one tenant in the west hallway to ensure the door was closed to prevent her from waking up from the noise the male tenant made. She stated "it did not come to my mind honestly to check on Tenant #C1" after she acknowledged the issue with the door alerts, that Tenant #C1 required a door alarm for her safety due to wandering, and Tenant #C1 slept lightly.

On 1-25-22 at 10:38 a.m. Staff B reported the following:
She arrived at the memory care unit around 10 p.m. on 1-20-22 and started to sanitize the

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equipment. Staff A arrived and wanted to work in the memory care unit so she walked back to the front to work in the assisted living part of the building. No door alert appeared on her IPAD when she opened it. The IPAD's battery died before the end of her shift and went to the office for a replacement. She noticed the desktop computer monitor had door alerts for the East Garden door and Tenant #C1's apartment door. She walked to the memory care and observed Staff A in the laundry room. She told her she was checking the alarms and Staff A did not respond. She observed Tenant #C1's apartment door was open, checked inside, and yelled to Staff A "she is not in her room". Staff A arrived and both went to the exit door near her apartment. She observed Tenant #C1's clothing on the handrail and saw shoes when she opened the exit door. Both staff moved Tenant #C1 inside and got blankets to cover her. She called the Healthcare Coordinator and received instructions to call 911. Tenant #C1 made some noise but was unresponsive. Tenant #C1 wore a sweater, pants, shoes, but no coat, hat, or gloves. EMS arrived for Tenant #C1 and as they left she observed Tenant #C1 open her eyes as they exited the building. Tenant #C1 had a history of being up and down throughout the night and asked about the location of stairs, elevators, her dog, or her car. She attempted distractions to redirect Tenant #C1 when this occurred and attempted to keep her in her sight due to her history of exit seeking. The memory care residents required hourly checks with eyes on the person to confirm their presence and documented when they are done. The past few weeks Tenant #C1's door alarm continued to send alerts even when closed and at times the IPAD failed to receive door alerts once in while. She assumed the Assistant Director knew about the issue with Tenant #C1's alarm but not sure if

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A 150	Continued From page 10 she knew about the issues with the IPAD. On 1-24-22 at 2:17 p.m. Staff C stated the following: She worked 2 p.m. to 10 p.m. on 1-20-22 in the memory care unit and Tenant #C1 spent most the shift in her room until supper time. Tenant #C1's anxiety increased during this time and she administered medication for her anxiety. Tenant #C1 slept in her room after supper until approximately 9-9:30 p.m. when she joined Staff E, Staff C, and another tenant in the TV room. Staff E and her IPADs were charging and not with them but Staff D in the assisted living side had an IPAD. The exit door had an audible alarm and she would be able to hear it if in the area but stated it may be hard to hear it if busy with other tenants or in an apartment. They relied on the IPAD to notify staff of door alarms. During shift change no one acknowledged a door alert and Tenant #C1 remained in the TV room and she left after 10 p.m. Hourly checks are required to be done and documented on each tenant. The door alarm system "Ariel" alerts failed to appear on the IPADS occasionally and informed the previous Director of the issue. Other staff talked about this issue and new IPADs had been ordered by the new Director. The door alarm on Tenant #C1's door alarmed even when shut and had done so for at least one month. The alarm appeared on the IPAD and no one cleared it due to the continuous alarm. All staff knew the door alarm failed to work properly and the issue was discussed at team meetings. The maintenance man failed to fix the issue before he left employment. She failed to have a charged IPAD with her as required and did not think to check all exit doors knowing the IPAD failed to receive alerts on occasion. She assumed Tenant #C1 may have tried to open the exit door by her	A 150		

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apartment prior to coming to the TV room.

On 1-24-22 at 3:55 p.m. Staff D reported the following:
She worked 2 p.m. to 10 p.m. on 1-20-22 on the assisted living side of the building and worked in the memory care unit at times. Tenant #C1 required medication for anxiety in the evening when the sun went down and would look for her husband, her baby, and/or her car, had a history of elopement, and would exit seek at times. Tenant #C1 liked to go to bed after supper and all staff knew she required supervision to prevent elopement. Staff knew her apartment door alarm failed to work properly and alarmed every two minutes. At first staff checked every time but as it continued, the staff checked the hallway once in a while due to the continuous alarm. Tenant #C1 packed up her belongings often and would say she was going home.

On 1-25-22 at 3:42 p.m. Staff D confirmed she knew neither staff in the memory care unit carried a charged IPAD and assumed responsibility to notify them if anything appeared on her IPAD. This occurred often and the only alert she observed was Tenant #C1's apartment door alarm every 2 minutes. There had been issues with "Ariel" and alerts failed to come through to the IPAD once in a while.

On 1-25-22 at 1:07 p.m. Staff E stated the following:
She worked 2 p.m. to 10 p.m. on 1-20-22 in the assisted living area until 7 p.m. then worked in the memory care unit until 10 p.m. Staff C completed most of the required tasks and they hung out with another tenant watching TV in the TV room around 9 p.m. She observed Tenant #C1 enter the area holding a little red purse. She

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gave her IPAD to Staff G who worked on the assisted living side and Staff C's battery died and was on the charger. At least one person on the shift was required to have an IPAD at all times. Four IPADS were available when fully charged and only 2 chargers worked currently. A fully charged tablet would last a shift but when given to the oncoming shift it would require charging at some point. Her IPAD died a few times on her shift and she notified the other staff to alert her if a door alarm went off. The Director was aware and new IPADS were ordered a while ago. Door alerts failed to appear on the IPAD a couple of times and she thought management had knowledge of this issue. The door on Tenant #C1's door failed to work properly and would alarm even when the door was shut. She informed the previous maintenance man sometime before Christmas but he is no longer employed. Hourly safety were required in the memory care unit to ensure everyone is accounted for and she received re-training on the door alarm policy and visual checks.

On 1-24-22 at 3:31 p.m. Staff F reported the following:
She worked in the memory care unit and Tenant #C1 resided in memory care for a few years. An alarm had been placed on her apartment door approximately one and half years ago and had an ankle monitor applied approximately one year ago. Tenant #C1 required these for her safety due to a history of elopement attempts and occurred more often on the 2 p.m. to 10 p.m. shifts due to her preference to sleep in. It would not be unusual for Tenant #C1 to move her belongings into the hallway in an attempt to leave and she required enhanced supervision and safety checks to be documented when completed. The system time stamps the documented checks to ensure

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they are completed as required. Tenant #C1 regularly approached exit doors in the unit and required the alarms and ankle monitor for safety. Tenant #C1's apartment door alarm worked as long as the door remained shut. Tenant #C1 preferred to keep the door open, would regularly go in/out of her apartment, and this resulted in a continuous alarm. The exit door had to be pushed for 15 seconds before it would open and required someone to push the green button by the door to clear the alarm from the IPAD.

On 2-1-22 at 3:21 p.m. Staff G confirmed the door alerts failed to appear on the IPAD at times and reported this to the Executive Director on 12-28-21.

The Executive Director (ED) revealed the following:
*On 1-24-22 at 12:55 p.m. she stated the Program has three cameras in the memory care unit. One camera was located in the common area facing the exit hallway to the assisted living portion of the building and records video 24 hours a day. The other two cameras were located at the end of each hallway above the exit doors. Those cameras did not record video but allowed staff to observe the area when accessed. New cameras were being installed to record all areas 24 hours per day. Tenant #C1 resided near the exit where staff found her. She received doors alerts on her phone via text message the East Garden Door and Tenant #C1's apartment door were breached but she failed to hear them because she was asleep. The text alert on her phone was difficult to hear and it failed to wake her up. Screenshots of her phone revealed she received the first alert at 9:44 p.m. on 1-20-22 for the East Garden Door and continued to receive them every five minutes and door alerts for Tenant #C1's apartment door

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alarm every 5 minutes from around 4:30 p.m. 1-20-22 until early morning 1-21-22.

*On 1-25-22 at 11:32 a.m. she confirmed Tenant #C1 propped her door open frequently and allowed the alert to go off continuously. She stated she failed to check on it each time because it occurred often.

*On 1-26-22 at 9:46 a.m. two staff informed her they had issues with the IPADs not working properly during an elopement drill on 12-28-21. The IPAD 's failed to make noise and the system for the door alarms didn't always work. She assumed staff turned down the volume at times and failed to hear the alert. On 1-21-22 the Clinical Educator checked every IPAD and found no issues. New IPADs were ordered prior to the elopement drill. The Healthcare Coordinator covered the on-call duties on 1-20-22 and didn't know why she failed to respond to the door alerts. Tenant #C1 required a door alarm for her safety and the door alarm failed to work properly for over one month. Staff reported the door alarmed constantly at times even when the door was shut. The alarm was installed with double sided tape, continued to slip out of alignment, and failed to have it securely installed to prevent this from happening.

*On 1-26-22 at 1:22 p.m. she confirmed the door must be shut to clear and reset the alarm on Tenant #C1's door.

On 1-25-22 at 9:37 a.m. the Portfolio Leader confirmed the Program recognized the need to develop a new system to alert management by a phone call instead of text to ensure they hear the alert, discussed installing a different type of exit doors, and purchased new camera systems to

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A 150	Continued From page 15 record 24 hours a day in all areas to be installed immediately. On 1-26-22 at 10:00 a.m. this surveyor and the Senior Portfolio Leader stood in the TV room and adjusted the volume on the TV to a moderate level. The Executive Director walked to the East Garden Door to open it and set off the alarm. This surveyor heard a faint alarm and confirmed with the Senior Portfolio Leader if the TV volume was increased and the staff engaged in loud conversation with the tenant present around 9:30 p.m., the alarm may not have been heard. On 2-2-22 at 11:54 a.m. the Registered Nurse (RN) reported the following: She worked 1-20-22 as the on-call nurse that evening and noticed the on-going door alerts for Tenant #C1 on her work phone. She failed to respond to them due to being with her family and was in bed around 9:30 p.m. She ignored the alerts in the past because Tenant #C1 opened the door constantly. The Program provided no training related to monitoring the phone for the door alerts and stated that wasn't part of the on-call expectations per the Executive Director. The expectation was to answer phone calls from staff and not to monitor the phone while on-call. Staff received door alerts to their IPADs and she expected them to watch for them and felt that wasn't something she needed to monitor. Tenant #C1 required an alarm on her apartment door due to wandering and exit seeking behavior and often got into other tenants belongings. Staff reported door alerts failed to come through the IPAD at times and new IPADs were ordered some time ago. She should have called the staff to check on things but assumed the staff would take care of it. She delegated all staff on visual checks, door alarms, and POC during a skills fair	A 150		

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A 150	Continued From page 16 in November 2021. They understood the training and signed the paperwork acknowledging competency. She delegated Staff A one on one and signed off on the training. On 2-2-22 at 3:37 p.m. the Clinical Care Coordinator stated she completed a Quality Assurance review with the RN on 12-20-21 and included to "continue to monitor Pendant and Security Response times-Escalating Call". She explained the Escalating Call sent the door alerts to the cell phones provided to the Director and Nurse to monitor as part of their job. The Senior Portfolio Leader confirmed these findings on 3-14-22 at 3:10 p.m.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide adequate and appropriate care, treatment, and services to 2 of 9 discharged tenants reviewed (Tenant #C1 and Tenant #C2). Findings follow: 1. Record review of Tenant #C1's file on 1-25-22 revealed the following: Incident Report dated 1-21-22 revealed at	A 160		

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A 160	Continued From page 17 approximately 6:19 a.m. the Registered Nurse (RN) received a call from Staff B who reported Tenant #C1 was found outside of the East Garden Door in the memory care unit. Staff brought her inside and covered her with blankets and immediately called 911. They reported she failed to respond but then found a pulse. Emergency services arrived and transported Tenant #C1 to the hospital. Around 8:55 a.m. the Sheriff arrived to investigate and informed the Program Tenant #C1 passed away at the hospital. Staff noted she wore long pants, a sweater, and shoes with the temperature noted to be around 7 degrees below zero. The Service Plan dated 11-13-21 revealed she required assistance with activities, bathing, toileting, medications, and received hospice services. Continued review noted forgetfulness, mild to moderate disorientation, difficulty retaining information, wore a wanderguard for added safety, and required hourly safety checks. Further review revealed diagnoses of Alzheimer's disease, major depressive disorder, and anxiety disorder. The Global Deterioration Scale completed 8-13-21 revealed a score of 5 and indicated moderately severe cognitive decline. A 90 Day Review dated 11-13-21 revealed she continued to have episodes of anxiety, packed up her room, and attempted to leave the community. She exit seeked and wandered at times of high anxiety and had PRN (as needed) medications to assist with behavior and had been effective. A Century System had been placed on her apartment door to assist with monitoring and had been effective this quarter with no elopements.	A 160		

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A 160	Continued From page 18 2. Documents and surveillance video provided by the Program confirmed the following: Documentation Survey Reports revealed Staff A failed to complete and document hourly safety checks on December 28, 2021 at 10:00 p.m. until December 29, 2021 at 6 a.m., December 29, 2021 at 10:00 p.m. until December 30, 2021 at 6 a.m, and January 20, 2022 at 10:00 p.m. until January 21, 2022 at 6 a.m. Device Activity Report revealed E5 East Garden Door alarmed at 9:34 p.m. on 1-20-22 until cleared at 6:12 a.m. on 1-21-22. Tenant #C1's door alarmed at 4:23 p.m. on 1-20-22 until cleared at 7:15 a.m. on 1-21-22. On 1-20-22 video footage recorded Staff A arriving after 10 p.m. Continued review showed her walking around the unit from approximately 11:09 p.m. until 2:44 a.m. and failed to walk down the east hallway to complete safety checks. A male tenant walked around the unit and appeared to fall asleep in a chair. Further review revealed around 2:44 a.m. until 6:10 a.m. she continued to walk around the memory care unit. She walked over to the assisted living area two times, and walked past the sleeping male tenant several times. She failed to walk down the east hallway throughout the night to complete hourly checks as required. 3. Record review of the hospital's emergency room documentation revealed Tenant #C1 arrived at 7:23 a.m. on 1-21-22. The Pre-Arrival Summary noted the chief complaint to be "hypothermia, cold, stiff, ice freezing on her, responsive to pain, head and hand abrasion". Further review revealed en route her pulse was 40 beats per minute and when pulse was lost,	A 160		

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A 160	Continued From page 19 EMS (Emergence Medical Services) performed CPR for approximately 90 seconds. Upon arrival at the hospital, EMS noted a slight pulse and when brought in to the emergency room, no pulse could be obtained. EMS stated she was too cold to obtain a temperature. Continued review revealed her temperature to be around 25 degrees Celsius (77 degrees Fahrenheit). Family was contacted and determined efforts to be ceased due to lack of expected meaningful recovery. The diagnosis was cardiac arrest and hypothermia and Tenant #C1 was deceased. 4. Record review of Polk County Medical Examiners Report of Autopsy documented pathologic diagnoses included heart failure and hypothermia due to cold exposure. Tenant #1's cause of death was documented as hypothermia (minutes) due to environmental cold exposure (hours) and the manner of death was documented as an accident. 5. According to the state climatologist the weather in Bondurant on 1-20-22 around 6:19 a.m. was -11 degrees Fahrenheit with relative humidity of 76%, the sky was clear, and the wind was calm with no windchill. 6. Record review on 2-7-22 of Tenant #C2's Service Plan dated 11-2-21 revealed she required 24 hour supervision and hourly safety checks. Review of Documentation Survey Report revealed Staff A failed to complete and document hourly safety checks from December 21, 2021 at 10:00 p.m. until December 21, 2022 at 6 a.m. 7. Record review on 1-31-22 of the Program's policy and procedures and job descriptions confirmed the following:	A 160		

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A 160	Continued From page 20 The Elopement Policy stated routine visual checks would be completed on tenants with confusion at or above Stage 4 on the Global Deterioration Scale. For tenants at risk of wandering, a Sentry System may be installed in individual apartments. If a tenant exited their apartment an emergency call would be activated to notify staff to check on the tenant. The system included visual checks eight times per shift. Staff were to watch for signs of wandering and confusion that may put the tenant at risk of elopement and if an exit door alarm sounds they should thoroughly check inside and outside areas triggered by the alarm. Nurse Delegation for Visual Checks required staff to enter the apartment and make visual contact of tenant, document visual check in Point of Care/Companion according to scheduled time to ensure tenant safety. If staff failed to see the tenant they were required to check the building until the tenant was located. Staff were required to ensure they completed all required documentation on all tenants. Nurse Delegation for Door Alarm Response revealed as staff received a notification to their IPAD of a door breached or opened, staff should immediately go to that door and observe inside and outside that door to find out who utilized the door. After knowing who used the door staff could push the green button, enter the code, on IPAD, etc to reset the door. The procedure included the alarms were in place to keep tenants safe. Ex. If a tenant exhibited increased confusion they may exit the community in inclement weather without being properly clothed. Nurse Delegation for Point of Care, EMAR or Companion revealed staff logged into program	A 160		

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with individualized and confidential login information. Staff selected the specific program for correct documentation and review required tasks. Staff logged out after ensuring all tasks had been completed to prevent use from an unauthorized person.

Community Manager job summary revealed the Director is on call 24/7 and maintained normal business hours 8 a.m. to 5 p.m. Monday through Friday. The Director's role included to ensure resources were in place to deliver quality essential services, to assure quality workmanship and performance was achieved by on-site staff. Continued review revealed Operational and Emergency Monitoring included to assure 24/7 coverage to carry on daily operational services and needs.

Healthcare Coordinator Essential Functions included to coordinate and implement the delivery of tenant care and to assure 24/7 coverage to respond to calls for urgent assistance from tenants of the Community, respond to fire alarms or other emergencies, and other duties as assigned.

8. Record review of staff files on 1-31-22 revealed the following:

Staff A signed the Elopement Policy on 6-9-21, the Nurse Delegation for Door Alarm Response, Visual Checks, and Point of Care delegations on 11-22-21, and acknowledged she was competent to complete the task as trained. On 1-3-22 she received a verbal warning over the phone from the LPN for failure to document tasks performed on her shift in Point Click Care on 12-30-21 as required. Corrective action included timely charting during her shift to reflect the cares

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provided to the tenants. On 1-28-22 the Program mailed a letter of termination effective 1-21-22.

Staff B signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-21-22 she received a written warning for failure to respond to door alarms as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants.

Staff C signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-21-22 she received a written warning for failure to respond to door alarms as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants.

Staff D signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-25-22 she received a written warning for failure to respond to door alarms and failure to carry an IPAD as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants.

Staff E signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-25-22 she received a written warning for failure to respond to door alarms and failure to carry an IPAD as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants.

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A 160	Continued From page 23 9. Staff interviews revealed the following: On 2-1-22 at 11:30 a.m. Staff A revealed the following: She started about six months ago and confirmed the Program provided training for safety checks and door alarms. Two staff usually worked in the memory care unit overnight and on 1-20-22 she was the only staff and Staff B worked in the assisted living area. She stated a male tenant yelled, banged, and attempted to exit the memory care unit at times that kept her busy throughout the entire shift. He wasn't wearing a jacket and required constant supervision to prevent him from going outside the door in the lounge area for most of her shift. Her IPAD was in the TV room and another IPAD was in the laundry room. The door alerts failed to appear on either IPAD. She provided a screen shot that revealed she texted the Executive Director in December 2021 the door alarm failed to show up on her tablet. Around 4 or 5 in the morning Staff B arrived and stated the computer showed the door alarm going off. She dropped everything, searched the area,and found Tenant #C1 outside the exit door in the East Hallway. Both staff brought her in and covered her with blankets and immediately called 911. She observed clothing hung and draped on the handrail and a purse near Tenant #C1. She confirmed knowledge of the camera located in the lounge above the exit door that recorded 24 hours per day and continued to state she worked on laundry and provided supervision to the male tenant throughout her shift. She confirmed Tenant #C1 required an alarm on her apartment door	A 160		

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because "she can leave and had a history of doing it" and stated "it is very important to check and make sure they are safe". The previous staff informed her everyone was ok and tenants were in their rooms and did not see Tenant #C1 at this time. She observed Tenant #C1's door was shut and failed to explain how she knew the door was shut when the video revealed she never walked down Tenant #C1's hallway. She failed to do rounds to check each tenant hourly as trained and continued to insist the male tenant required her full attention for the entire shift and prioritized keeping him from exiting the building.

This surveyor explained the video failed to match how she described her shift and revealed the male tenant asleep around 2:53. She stated she remained in the TV room from 3:32 am to 5:23 a.m. and peaked her head out to make sure he was ok. She prioritized monitoring the male tenant because the door alarms failed to show up on the tablet at times. She stated it "slipped my mind to do safety checks" down the east hallway. She checked on one tenant in the west hallway to ensure the door was closed to prevent her from waking up from the noise the male tenant made. She stated "it did not come to my mind honestly to check on Tenant #C1" after she acknowledged the issue with the door alerts, that Tenant #C1 required a door alarm for her safety due to wandering, and Tenant #C1 slept lightly.

On 1-25-22 at 10:38 a.m. Staff B reported the following:
She arrived at the memory care unit around 10 p.m. on 1-20-22 and started to sanitize the equipment. Staff A arrived and wanted to work in the memory care unit so she walked back to the front to work in the assisted living part of the building. No door alert appeared on her IPAD

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COURTYARD ESTATES AT HAWTHORNE CROSSING	601 HAWTHORNE CROSSING DR. SE BONDURANT, IA 50035

(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 160	Continued From page 25 when she opened it. The IPAD's battery died before the end of her shift and went to the office for a replacement. She noticed the desktop computer monitor had door alerts for the East Garden door and Tenant #C1's apartment door. She walked to the memory care and observed Staff A in the laundry room. She told her she was checking the alarms and Staff A did not respond. She observed Tenant #C1's apartment door was open, checked inside, and yelled to Staff A "she is not in her room". Staff A arrived and both went to the exit door near her apartment. She observed Tenant #C1's clothing on the handrail and saw shoes when she opened the exit door. Both staff moved Tenant #C1 inside and got blankets to cover her. She called the Healthcare Coordinator and received instructions to call 911. Tenant #C1 made some noise but was unresponsive. Tenant #C1 wore a sweater, pants, shoes, but no coat, hat, or gloves. EMS arrived for Tenant #C1 and as they left she observed Tenant #C1 open her eyes as they exited the building. Tenant #C1 had a history of being up and down throughout the night and asked about the location of stairs, elevators, her dog, or her car. She attempted distractions to redirect Tenant #C1 when this occurred and attempted to keep her in her sight due to her history of exit seeking. The memory care residents required hourly checks with eyes on the person to confirm their presence and documented when they are done. The past few weeks Tenant #C1's door alarm continued to send alerts even when closed and at times the IPAD failed to receive door alerts once in while. She assumed the Assistant Director knew about the issue with Tenant #C1's alarm but not sure if she knew about the issues with the IPAD. On 1-24-22 at 2:17 p.m. Staff C stated the following:	A 160		

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A 160	Continued From page 26 She worked 2 p.m. to 10 p.m. on 1-20-22 in the memory care unit and Tenant #C1 spent most the shift in her room until supper time. Tenant #C1's anxiety increased during this time and she administered medication for her anxiety. Tenant #C1 slept in her room after supper until approximately 9-9:30 p.m. when she joined Staff E, Staff C, and another tenant in the TV room. Staff E and her IPADs were charging and not with them but Staff D in the assisted living side had an IPAD. The exit door had an audible alarm and she would be able to hear it if in the area but stated it may be hard to hear it if busy with other tenants or in an apartment. They relied on the IPAD to notify staff of door alarms. During shift change no one acknowledged a door alert and Tenant #C1 remained in the TV room and she left after 10 p.m. Hourly checks are required to be done and documented on each tenant. The door alarm system "Ariel" alerts failed to appear on the IPADS occasionally and informed the previous Director of the issue. Other staff talked about this issue and new IPADs had been ordered by the new Director. The door alarm on Tenant #C1's door alarmed even when shut and had done so for at least one month. The alarm appeared on the IPAD and no one cleared it due to the continuous alarm. All staff knew the door alarm failed to work properly and the issue was discussed at team meetings. The maintenance man failed to fix the issue before he left employment. She failed to have a charged IPAD with her as required and did not think to check all exit doors knowing the IPAD failed to receive alerts on occasion. She assumed Tenant #C1 may have tried to open the exit door by her apartment prior to coming to the TV room. On 1-24-22 at 3:55 p.m. Staff D reported the following:	A 160		

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A 160	Continued From page 27 She worked 2 p.m. to 10 p.m. on 1-20-22 on the assisted living side of the building and worked in the memory care unit at times. Tenant #C1 required medication for anxiety in the evening when the sun went down and would look for her husband, her baby, and/or her car, had a history of elopement, and would exit seek at times. Tenant #C1 liked to go to bed after supper and all staff knew she required supervision to prevent elopement. Staff knew her apartment door alarm failed to work properly and alarmed every two minutes. At first staff checked every time but as it continued, the staff checked the hallway once in a while due to the continuous alarm. Tenant #C1 packed up her belongings often and would say she was going home. On 1-25-22 at 3:42 p.m. Staff D confirmed she knew neither staff in the memory care unit carried a charged IPAD and assumed responsibility to notify them if anything appeared on her IPAD. This occurred often and the only alert she observed was Tenant #C1's apartment door alarm every 2 minutes. There had been issues with "Ariel" and alerts failed to come through to the IPAD once in a while. On 1-25-22 at 1:07 p.m. Staff E stated the following: She worked 2 p.m. to 10 p.m. on 1-20-22 in the assisted living area until 7 p.m. then worked in the memory care unit until 10 p.m. Staff C completed most of the required tasks and they hung out with another tenant watching TV in the TV room around 9 p.m. She observed Tenant #C1 enter the area holding a little red purse. She gave her IPAD to Staff G who worked on the assisted living side and Staff C's battery died and was on the charger. At least one person on the shift was required to have an IPAD at all times.	A 160		

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A 160	Continued From page 28 Four IPADS were available when fully charged and only 2 chargers worked currently. A fully charged tablet would last a shift but when given to the oncoming shift it would require charging at some point. Her IPAD died a few times on her shift and she notified the other staff to alert her if a door alarm went off. The Director was aware and new IPADS were ordered a while ago. Door alerts failed to appear on the IPAD a couple of times and she thought management had knowledge of this issue. The door on Tenant #C1's door failed to work properly and would alarm even when the door was shut. She informed the previous maintenance man sometime before Christmas but he is no longer employed. Hourly safety were required in the memory care unit to ensure everyone is accounted for and she received re-training on the door alarm policy and visual checks. On 1-24-22 at 3:31 p.m. Staff F reported the following: She worked in the memory care unit and Tenant #C1 resided in memory care for a few years. An alarm had been placed on her apartment door approximately one and half years ago and had an ankle monitor applied approximately one year ago. Tenant #C1 required these for her safety due to a history of elopement attempts and occurred more often on the 2 p.m. to 10 p.m. shifts due to her preference to sleep in. It would not be unusual for Tenant #C1 to move her belongings into the hallway in an attempt to leave and she required enhanced supervision and safety checks to be documented when completed. The system time stamps the documented checks to ensure they are completed as required. Tenant #C1 regularly approached exit doors in the unit and required the alarms and ankle monitor for safety. Tenant #C1's apartment door alarm worked as	A 160		

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long as the door remained shut. Tenant #C1 preferred to keep the door open, would regularly go in/out of her apartment, and this resulted in a continuous alarm. The exit door had to be pushed for 15 seconds before it would open and required someone to push the green button by the door to clear the alarm from the IPAD.

On 2-1-22 at 3:21 p.m. Staff G confirmed the door alerts failed to appear on the IPAD at times and reported this to the Executive Director on 12-28-21.

The Executive Director (ED) revealed the following:
*On 1-24-22 at 12:55 p.m. she stated the Program has three cameras in the memory care unit. One camera was located in the common area facing the exit hallway to the assisted living portion of the building and records video 24 hours a day. The other two cameras were located at the end of each hallway above the exit doors. Those cameras did not record video but allowed staff to observe the area when accessed. New cameras were being installed to record all areas 24 hours per day. Tenant #C1 resided near the exit where staff found her. She received doors alerts on her phone via text message the East Garden Door and Tenant #C1's apartment door were breached but she failed to hear them because she was asleep. The text alert on her phone was difficult to hear and it failed to wake her up. Screenshots of her phone revealed she received the first alert at 9:44 p.m. on 1-20-22 for the East Garden Door and continued to receive them every five minutes and door alerts for Tenant #C1's apartment door alarm every 5 minutes from around 4:30 p.m. 1-20-22 until early morning 1-21-22.

*On 1-25-22 at 11:32 a.m. she confirmed Tenant

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#C1 propped her door open frequently and allowed the alert to go off continuously. She stated she failed to check on it each time because it occurred often.

*On 1-26-22 at 9:46 a.m. two staff informed her they had issues with the IPADs not working properly during an elopement drill on 12-28-21. The IPAD 's failed to make noise and the system for the door alarms didn't always work. She assumed staff turned down the volume at times and failed to hear the alert. On 1-21-22 the Clinical Educator checked every IPAD and found no issues. New IPADs were ordered prior to the elopement drill. The Healthcare Coordinator covered the on-call duties on 1-20-22 and didn't know why she failed to respond to the door alerts. Tenant #C1 required a door alarm for her safety and the door alarm failed to work properly for over one month. Staff reported the door alarmed constantly at times even when the door was shut. The alarm was installed with double sided tape, continued to slip out of alignment, and failed to have it securely installed to prevent this from happening.

*On 1-26-22 at 1:22 p.m. she confirmed the door must be shut to clear and reset the alarm on Tenant #C1's door.

On 1-25-22 at 9:37 a.m. the Portfolio Leader confirmed the Program recognized the need to develop a new system to alert management by a phone call instead of text to ensure they hear the alert, discussed installing a different type of exit doors, and purchased new camera systems to record 24 hours a day in all areas to be installed immediately.

On 1-26-22 at 10:00 a.m. this surveyor and the

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A 160	Continued From page 31 Senior Portfolio Leader stood in the TV room and adjusted the volume on the TV to a moderate level. The Executive Director walked to the East Garden Door to open it and set off the alarm. This surveyor heard a faint alarm and confirmed with the Senior Portfolio Leader if the TV volume was increased and the staff engaged in loud conversation with the tenant present around 9:30 p.m., the alarm may not have been heard. On 2-2-22 at 11:54 a.m. the Registered Nurse (RN) reported the following: She worked 1-20-22 as the on-call nurse that evening and noticed the on-going door alerts for Tenant #C1 on her work phone. She failed to respond to them due to being with her family and was in bed around 9:30 p.m. She ignored the alerts in the past because Tenant #C1 opened the door constantly. The Program provided no training related to monitoring the phone for the door alerts and stated that wasn't part of the on-call expectations per the Executive Director. The expectation was to answer phone calls from staff and not to monitor the phone while on-call. Staff received door alerts to their IPADs and she expected them to watch for them and felt that wasn't something she needed to monitor. Tenant #C1 required an alarm on her apartment door due to wandering and exit seeking behavior and often got into other tenants belongings. Staff reported door alerts failed to come through the IPAD at times and new IPADs were ordered some time ago. She should have called the staff to check on things but assumed the staff would take care of it. She delegated all staff on visual checks, door alarms, and POC during a skills fair in November 2021. They understood the training and signed the paperwork acknowledging competency. She delegated Staff A one on one and signed off on the training.	A 160		

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A 160	Continued From page 32 On 2-2-22 at 3:37 p.m. the Clinical Care Coordinator stated she completed a Quality Assurance review with the RN on 12-20-21 and included to "continue to monitor Pendant and Security Response times-Escalating Call". She explained the Escalating Call sent the door alerts to the cell phones provided to the Director and Nurse to monitor as part of their job. The Senior Portfolio Leader confirmed these findings on 3-14-22 at 3:10 p.m.	A 160		
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 develop an individualized service plan to indicate identified needs and preferences for assistance for 1 of 9 discharged tenants reviewed (Tenant #C1). Findings follow: 1. Record review of Tenant #C1's file on 1-25-22 revealed the following: The Service Plan dated 11-13-21 revealed she resided in the locked memory care unit and had diagnoses of Alzheimer's disease, major depressive disorder, and anxiety disorder. Continued review of her service plan revealed she had mild to moderate disorientation,	A 395		

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experienced anxiety and/or agitation, wore a Wanderguard for added safety, and required hourly safety checks. The Service Plan failed to include Tenant #C1's history of exit seeking behavior, opening exit doors, packing her clothes with the intent to leave, and the door alarm installed on her apartment door to alert staff when she exited her apartment.

The Global Deterioration Scale completed 8-13-21 revealed a score of 5 and indicated moderately severe cognitive decline.

A 90 Day Review dated 11-13-21 revealed she continued to have episodes of anxiety, packed up her room, and attempted to leave the community. She exit seeked and wandered at times of high anxiety and had PRN (as needed) medications to assist with behavior and had been effective. A Century System had been placed on her apartment door to assist with monitoring and had been effective this quarter with no elopements.

Incident Report dated 1-21-22 revealed at approximately 6:19 a.m. the Registered Nurse (RN) received a call from Staff B who reported Tenant #C1 was found outside of the East Garden Door in the memory care unit. Staff brought her inside and covered her with blankets and immediately called 911. They reported she failed to respond but then found a pulse. Emergency services arrived and transported Tenant #C1 to the hospital. Around 8:55 a.m. the Sheriff arrived to investigate and informed the Program Tenant #C1 passed away at the hospital. Staff noted she wore long pants, a sweater, and shoes with the temperature noted to be around 7 degrees below zero.

2. Staff interviews revealed the following:

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A 395	Continued From page 34 On 2-1-22 at 11:30 a.m. Staff A confirmed Tenant #C1 required an alarm on her apartment door because "she can leave and had a history of doing it" and stated "it is very important to check and make sure they are safe". On 1-25-22 at 10:38 a.m. Staff B stated stated Tenant #C1 had a history of being up and down throughout the night and asked about the location of stairs, elevators, her dog, or her car. She attempted distractions to redirect Tenant #C1 when this occurred and attempted to keep her in her sight due to her history of exit seeking. She confirmed the past few weeks Tenant #C1's door alarm continued to send alerts even when closed and at times the IPAD failed to receive door alerts once in while. She assumed the Assistant Director knew about the issue with Tenant #C1's alarm. On 1-24-22 at 3:55 p.m. Staff D confirmed Tenant #C1 required medication for anxiety in the evening when the sun went down. Tenant #C1 looked for her husband, her baby, and/or her car, and exit seeked during these times. Tenant #C1 liked to go to bed after supper and all staff knew she required supervision to prevent elopement. Staff knew her apartment door alarm failed to work properly and alarmed every two minutes. At first staff checked every time but as it continued the staff checked the hallway once in a while due to the continuous alarm. She reported Tenant #C1 packed up her belongings often and stated she was going home and had a history of elopement attempts. On 1-24-22 at 3:31 p.m. Staff F stated she worked in the memory care unit and Tenant #C1 resided there for a few years. An alarm had been	A 395		

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A 395	Continued From page 35 placed on her apartment door approximately one and half years ago and had an ankle monitor applied approximately one year ago. Tenant #C1 required these for her safety due to a history of elopement attempts and occurred more often on the 2 p.m. to 10 p.m. shifts due to her preference to sleep in. It would not be unusual for Tenant #C1 to move her belongings into the hallway in an attempt to leave and she required enhanced supervision and safety checks to be documented when completed. On 1-25-22 at 11:32 a.m. the Executive Director (ED) reported Tenant #C1 propped her door open frequently which allowed the alert to go off continuously and she failed to check on it each time because it occurred often. On 1-26-22 at 9:46 a.m. the ED confirmed Tenant #C1 required a door alarm for her safety. The Senior Portfolio Leader confirmed these findings on 3-14-22 at 3:10 p.m.	A 395		
A 530	481-69.29(4) Staffing 481-69.29(231C) Staffing. 69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans. A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan.	A 530		

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A 530	Continued From page 36 The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to monitor tenants as indicated in the service plans for 2 of 9 discharged tenants reviewed (Tenant #C1 and Tenant #C2) and potentially affected all tenants in the memory care unit. Findings follow: 1. Record review of Tenant #C1's file on 1-25-22 revealed the following: The Service Plan dated 11-13-21 revealed she resided in the locked memory care unit and had diagnoses of Alzheimer's disease, major depressive disorder, and anxiety disorder. Continued review of her service plan revealed she had mild to moderate disorientation, experienced anxiety and/or agitation, wore a Wanderguard for added safety, and required hourly safety checks. The Global Deterioration Scale completed 8-13-21 revealed a score of 5 and indicated moderately severe cognitive decline. A 90 Day Review dated 11-13-21 revealed she continued to have episodes of anxiety, packed up her room, and attempted to leave the community. She exit seeked and wandered at times of high anxiety and had PRN (as needed) medications to assist with behavior and had been effective. A Century System had been placed on her	A 530		

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A 530	Continued From page 37	A 530		

apartment door to assist with monitoring and had been effective this quarter with no elopements.

Incident Report dated 1-21-22 revealed at approximately 6:19 a.m. the Registered Nurse (RN) received a call from Staff B who reported Tenant #C1 was found outside of the East Garden Door in the memory care unit. Staff brought her inside and covered her with blankets and immediately called 911. They reported she failed to respond but then found a pulse. Emergency services arrived and transported Tenant #C1 to the hospital. Around 8:55 a.m. the Sheriff arrived to investigate and informed the Program Tenant #C1 passed away at the hospital. Staff noted she wore long pants, a sweater, and shoes with the temperature noted to be around 7 degrees below zero.

2. Documents and surveillance video provided by the Program confirmed the following:

Documentation Survey Reports revealed Staff A failed to complete and document hourly safety checks on December 28, 2021 at 10:00 p.m. until December 29, 2021 at 6 a.m., December 29, 2021 at 10:00 p.m. until December 30, 2021 at 6 a.m, and January 20, 2022 at 10:00 p.m. until January 21, 2022 at 6 a.m.

Device Activity Report revealed E5 East Garden Door alarmed at 9:34 p.m. on 1-20-22 until cleared at 6:12 a.m. on 1-21-22. Tenant #C1's door alarmed at 4:23 p.m. on 1-20-22 until cleared at 7:15 a.m. on 1-21-22.

On 1-20-22 video footage recorded Staff A arriving after 10 p.m. Continued review showed her walking around the unit from approximately 11:09 p.m. until 2:44 a.m. and failed to walk down

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD ESTATES AT HAWTHORNE CROSSING	601 HAWTHORNE CROSSING DR. SE BONDURANT, IA 50035

(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 530	Continued From page 38	A 530		

the east hallway to complete safety checks. A male tenant walked around the unit and appeared to fall asleep in a chair. Further review revealed around
2:44 a.m. until 6:10 a.m. she continued to walk around the memory care unit. She walked over to the assisted living area two times, and walked past the sleeping male tenant several times. She failed to walk down the east hallway throughout the night to complete hourly checks as required.

3. Record review of the hospital's emergency room documentation revealed Tenant #C1 arrived at 7:23 a.m. on 1-21-22. The Pre-Arrival Summary noted the chief complaint to be "hypothermia, cold, stiff, ice freezing on her, responsive to pain, head and hand abrasion". Further review revealed en route her pulse was 40 beats per minute and when pulse was lost, EMS (Emergence Medical Services) performed CPR for approximately 90 seconds. Upon arrival at the hospital, EMS noted a slight pulse and when brought in to the emergency room, no pulse could be obtained. EMS stated she was too cold to obtain a temperature. Continued review revealed her temperature to be around 25 degrees Celsius (77 degrees Fahrenheit). Family was contacted and determined efforts to be ceased due to lack of expected meaningful recovery. The diagnosis was cardiac arrest and hypothermia and Tenant #C1 was deceased.

4. Record review of Polk County Medical Examiners Report of Autopsy documented pathologic diagnoses included heart failure and hypothermia due to cold exposure. Tenant #1's cause of death was documented as hypothermia (minutes) due to environmental cold exposure (hours) and the manner of death was documented as an accident.

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A 530	Continued From page 39 5. According to the state climatologist the weather in Bondurant on 1-20-22 around 6:19 a.m. was -11 degrees Fahrenheit with relative humidity of 76%, the sky was clear, and the wind was calm with no windchill. 6. Record review on 2-7-22 of Tenant #C2's Service Plan dated 11-2-21 revealed she required 24 hour supervision and hourly safety checks. Review of Documentation Survey Report revealed Staff A failed to complete and document hourly safety checks from December 21, 2021 at 10:00 p.m. until December 21, 2022 at 6 a.m. 7. Record review on 1-31-22 of the Program's policy and procedures and job descriptions confirmed the following: The Elopement Policy stated routine visual checks would be completed on tenants with confusion at or above Stage 4 on the Global Deterioration Scale. For tenants at risk of wandering, a Sentry System may be installed in individual apartments. If a tenant exited their apartment an emergency call would be activated to notify staff to check on the tenant. The system included visual checks eight times per shift. Staff were to watch for signs of wandering and confusion that may put the tenant at risk of elopement and if an exit door alarm sounds they should thoroughly check inside and outside areas triggered by the alarm. Nurse Delegation for Visual Checks required staff to enter the apartment and make visual contact of tenant, document visual check in Point of Care/Companion according to scheduled time to ensure tenant safety. If staff failed to see the tenant they were required to check the building	A 530		

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A 530	Continued From page 40 until the tenant was located. Staff were required to ensure they completed all required documentation on all tenants. The Senior Portfolio Leader confirmed these findings on 3-14-22 at 3:10 p.m.	A 530		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide 8 hours of dementia training within 30 days of employment for 1 of 7 staff reviewed as a result of Incident #101735-I (Staff A). Findings follow: Record review of staff files on 1-25-22 revealed the following: 1. Staff A was hired 5-12-21 and completed 4.75 hours of dementia training by 6-9-21. No further dementia training within 30 days of employment could be located. The Senior Portfolio Leader confirmed these findings on 1-26-22 at 10:12 a.m.	A 545		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure	A 635		

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A 635	Continued From page 41 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 ensure an operating alarm system was connected to exit doors of a dementia unit for 1 of 1 tenants reviewed (Tenant #C1) as a result of 101735-I and potentially affected all tenants in the memory care unit. Findings follow: 1. Record review of Tenant #C1's file on 1-25-22 revealed the following: Incident Report dated 1-21-22 revealed at approximately 6:19 a.m. the Registered Nurse (RN) received a call from Staff B who reported Tenant #C1 was found outside of the East Garden Door in the memory care unit. Staff brought her inside and covered her with blankets and immediately called 911. They reported she failed to respond but then found a pulse. Emergency services arrived and transported Tenant #C1 to the hospital. Around 8:55 a.m. the Sheriff arrived to investigate and informed the Program Tenant #C1 passed away at the hospital. Staff noted she wore long pants, a sweater, and shoes with the temperature noted to be around 7 degrees below zero. The Service Plan dated 11-13-21 revealed she required assistance with activities, bathing, toileting, medications, and received hospice services. Continued review noted forgetfulness, mild to moderate disorientation, difficulty retaining information, wore a wanderguard for added	A 635		

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A 635	Continued From page 42	A 635		

safety, and required hourly safety checks. Further review revealed diagnoses of Alzheimer's disease, major depressive disorder, and anxiety disorder.

The Global Deterioration Scale completed 8-13-21 revealed a score of 5 and indicated moderately severe cognitive decline.

A 90 Day Review dated 11-13-21 revealed she continued to have episodes of anxiety, packed up her room, and attempted to leave the community. She exit seeked and wandered at times of high anxiety and had PRN (as needed) medications to assist with behavior and had been effective. A Century System had been placed on her apartment door to assist with monitoring and had been effective this quarter with no elopements.

2. Documents and surveillance video provided by the Program confirmed the following:

Documentation Survey Reports revealed Staff A failed to complete and document hourly safety checks on December 28, 2021 at 10:00 p.m. until December 29, 2021 at 6 a.m., December 29, 2021 at 10:00 p.m. until December 30, 2021 at 6 a.m, and January 20, 2022 at 10:00 p.m. until January 21, 2022 at 6 a.m.

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On 1-20-22 video footage recorded Staff A arriving after 10 p.m. Continued review showed her walking around the unit from approximately 11:09 p.m. until 2:44 a.m. and failed to walk down

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A 635	Continued From page 43	A 635		

the east hallway to complete safety checks. A male tenant walked around the unit and appeared to fall asleep in a chair. Further review revealed around
2:44 a.m. until 6:10 a.m. she continued to walk around the memory care unit. She walked over to the assisted living area two times, and walked past the sleeping male tenant several times. She failed to walk down the east hallway throughout the night to complete hourly checks as required.

3. Record review of the hospital's emergency room documentation revealed Tenant #C1 arrived at 7:23 a.m. on 1-21-22. The Pre-Arrival Summary noted the chief complaint to be "hypothermia, cold, stiff, ice freezing on her, responsive to pain, head and hand abrasion". Further review revealed en route her pulse was 40 beats per minute and when pulse was lost, EMS (Emergence Medical Services) performed CPR for approximately 90 seconds. Upon arrival at the hospital, EMS noted a slight pulse and when brought in to the emergency room, no pulse could be obtained. EMS stated she was too cold to obtain a temperature. Continued review revealed her temperature to be around 25 degrees Celsius (77 degrees Fahrenheit). Family was contacted and determined efforts to be ceased due to lack of expected meaningful recovery. The diagnosis was cardiac arrest and hypothermia and Tenant #C1 was deceased.

4. Record review of Polk County Medical Examiners Report of Autopsy documented pathologic diagnoses included heart failure and hypothermia due to cold exposure. Tenant #1's cause of death was documented as hypothermia (minutes) due to environmental cold exposure (hours) and the manner of death was documented as an accident.

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A 635	Continued From page 44 5. According to the state climatologist the weather in Bondurant on 1-20-22 around 6:19 a.m. was -11 degrees Fahrenheit with relative humidity of 76%, the sky was clear, and the wind was calm with no windchill. 6. Record review on 1-31-22 of the Program's policy and procedures and job descriptions confirmed the following: The Elopement Policy stated routine visual checks would be completed on tenants with confusion at or above Stage 4 on the Global Deterioration Scale. For tenants at risk of wandering, a Sentry System may be installed in individual apartments. If a tenant exited their apartment an emergency call would be activated to notify staff to check on the tenant. The system included visual checks eight times per shift. Staff were to watch for signs of wandering and confusion that may put the tenant at risk of elopement and if an exit door alarm sounds they should thoroughly check inside and outside areas triggered by the alarm. Nurse Delegation for Door Alarm Response revealed as staff received a notification to their IPAD of a door breached or opened, staff should immediately go to that door and observe inside and outside that door to find out who utilized the door. After knowing who used the door staff could push the green button, enter the code, on IPAD, etc to reset the door. The procedure included the alarms were in place to keep tenants safe. Ex. If a tenant exhibited increased confusion they may exit the community in inclement weather without being properly clothed. Nurse Delegation for Point of Care, EMAR or	A 635		

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A 635	Continued From page 45 Companion revealed staff logged into program with individualized and confidential login information. Staff selected the specific program for correct documentation and review required tasks. Staff logged out after ensuring all tasks had been completed to prevent use from an unauthorized person. Community Manager job summary revealed the Director is on call 24/7 and maintained normal business hours 8 a.m. to 5 p.m. Monday through Friday. The Director's role included to ensure resources were in place to deliver quality essential services, to assure quality workmanship and performance was achieved by on-site staff. Continued review revealed Operational and Emergency Monitoring included to assure 24/7 coverage to carry on daily operational services and needs. Healthcare Coordinator Essential Functions included to coordinate and implement the delivery of tenant care and to assure 24/7 coverage to respond to calls for urgent assistance from tenants of the Community, respond to fire alarms or other emergencies, and other duties as assigned. 7. Record review of staff files on 1-31-22 revealed the following: Staff A signed the Elopement Policy on 6-9-21, the Nurse Delegation for Door Alarm Response, Visual Checks, and Point of Care delegations on 11-22-21, and acknowledged she was competent to complete the task as trained. On 1-3-22 she received a verbal warning over the phone from the LPN for failure to document tasks performed on her shift in Point Click Care on 12-30-21 as required. Corrective action included timely	A 635		

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charting during her shift to reflect the cares provided to the tenants. On 1-28-22 the Program mailed a letter of termination effective 1-21-22.

Staff B signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-21-22 she received a written warning for failure to respond to door alarms as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants.

Staff C signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-21-22 she received a written warning for failure to respond to door alarms as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants.

Staff D signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-25-22 she received a written warning for failure to respond to door alarms and failure to carry an IPAD as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants.

Staff E signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-25-22 she received a written warning for failure to respond to door alarms and failure to carry an IPAD as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and

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A 635	Continued From page 47 pendants. 8. Staff interviews revealed the following: On 2-1-22 at 11:30 a.m. Staff A revealed the following: She started about six months ago and confirmed the Program provided training for safety checks and door alarms. Two staff usually worked in the memory care unit overnight and on 1-20-22 she was the only staff and Staff B worked in the assisted living area. She stated a male tenant yelled, banged, and attempted to exit the memory care unit at times that kept her busy throughout the entire shift. He wasn't wearing a jacket and required constant supervision to prevent him from going outside the door in the lounge area for most of her shift. Her IPAD was in the TV room and another IPAD was in the laundry room. The door alerts failed to appear on either IPAD. She provided a screen shot that revealed she texted the Executive Director in December 2021 the door alarm failed to show up on her tablet. Around 4 or 5 in the morning Staff B arrived and stated the computer showed the door alarm going off. She dropped everything, searched the area,and found Tenant #C1 outside the exit door in the East Hallway. Both staff brought her in and covered her with blankets and immediately called 911. She observed clothing hung and draped on the handrail and a purse near Tenant #C1. She confirmed knowledge of the camera located in the lounge above the exit door that recorded 24 hours per day and continued to state she worked on laundry and provided supervision to the male tenant throughout her shift. She confirmed Tenant	A 635		

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A 635	Continued From page 48 #C1 required an alarm on her apartment door because "she can leave and had a history of doing it" and stated "it is very important to check and make sure they are safe". The previous staff informed her everyone was ok and tenants were in their rooms and did not see Tenant #C1 at this time. She observed Tenant #C1's door was shut and failed to explain how she knew the door was shut when the video revealed she never walked down Tenant #C1's hallway. She failed to do rounds to check each tenant hourly as trained and continued to insist the male tenant required her full attention for the entire shift and prioritized keeping him from exiting the building. This surveyor explained the video failed to match how she described her shift and revealed the male tenant asleep around 2:53. She stated she remained in the TV room from 3:32 am to 5:23 a.m. and peaked her head out to make sure he was ok. She prioritized monitoring the male tenant because the door alarms failed to show up on the tablet at times. She stated it "slipped my mind to do safety checks" down the east hallway. She checked on one tenant in the west hallway to ensure the door was closed to prevent her from waking up from the noise the male tenant made. She stated "it did not come to my mind honestly to check on Tenant #C1" after she acknowledged the issue with the door alerts, that Tenant #C1 required a door alarm for her safety due to wandering, and Tenant #C1 slept lightly. On 1-25-22 at 10:38 a.m. Staff B reported the following: She arrived at the memory care unit around 10 p.m. on 1-20-22 and started to sanitize the equipment. Staff A arrived and wanted to work in the memory care unit so she walked back to the front to work in the assisted living part of the	A 635		

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building. No door alert appeared on her IPAD when she opened it. The IPAD's battery died before the end of her shift and went to the office for a replacement. She noticed the desktop computer monitor had door alerts for the East Garden door and Tenant #C1's apartment door. She walked to the memory care and observed Staff A in the laundry room. She told her she was checking the alarms and Staff A did not respond. She observed Tenant #C1's apartment door was open, checked inside, and yelled to Staff A "she is not in her room". Staff A arrived and both went to the exit door near her apartment. She observed Tenant #C1's clothing on the handrail and saw shoes when she opened the exit door. Both staff moved Tenant #C1 inside and got blankets to cover her. She called the Healthcare Coordinator and received instructions to call 911. Tenant #C1 made some noise but was unresponsive. Tenant #C1 wore a sweater, pants, shoes, but no coat, hat, or gloves. EMS arrived for Tenant #C1 and as they left she observed Tenant #C1 open her eyes as they exited the building. Tenant #C1 had a history of being up and down throughout the night and asked about the location of stairs, elevators, her dog, or her car. She attempted distractions to redirect Tenant #C1 when this occurred and attempted to keep her in her sight due to her history of exit seeking. The memory care residents required hourly checks with eyes on the person to confirm their presence and documented when they are done. The past few weeks Tenant #C1's door alarm continued to send alerts even when closed and at times the IPAD failed to receive door alerts once in while. She assumed the Assistant Director knew about the issue with Tenant #C1's alarm but not sure if she knew about the issues with the IPAD.

On 1-24-22 at 2:17 p.m. Staff C stated the

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following:
The exit door in the memory care unit had an audible alarm and she would be able to hear it if in the area but reported it may be hard to hear if staff were busy with other tenants or in an apartment. Staff relied on the IPAD to notify them of door alarms. During shift change no one acknowledged a door alert and Tenant #C1 remained in the TV room and she left after 10 p.m. Hourly checks are required to be done and documented on each tenant. The door alarm system "Ariel" alerts failed to appear on the IPADS occasionally and informed the previous Director of the issue. Other staff talked about this issue and new IPADs had been ordered by the new Director. The door alarm on Tenant #C1's door alarmed even when shut and had done so for at least one month. The alarm appeared on the IPAD and no one cleared it due to the continuous alarm. All staff knew the door alarm failed to work properly and the issue was discussed at team meetings. The maintenance man failed to fix the issue before he left employment. She failed to have a charged IPAD with her as required and did not think to check all exit doors knowing the IPAD failed to receive alerts on occasion. She assumed Tenant #C1 may have tried to open the exit door by her apartment prior to coming to the TV room.

On 1-24-22 at 3:55 p.m. Staff D reported the following:
She knew Tenant #C1's apartment door alarm failed to work properly and alarmed every two minutes. At first staff checked every time but as it continued, the staff checked the hallway once in a while due to the continuous alarm.

On 1-25-22 at 3:42 p.m. Staff D confirmed she knew neither staff in the memory care unit carried

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a charged IPAD and assumed responsibility to notify them if anything appeared on her IPAD. This occurred often and the only alert she observed was Tenant #C1's apartment door alarm every 2 minutes. There had been issues with "Ariel" and alerts failed to come through to the IPAD once in a while.

On 1-25-22 at 1:07 p.m. Staff E stated the following:
She gave her IPAD to Staff G who worked on the assisted living side and Staff C's battery died and was on the charger. At least one person on the shift was required to have an IPAD at all times. Four IPADS were available when fully charged and only 2 chargers worked currently. A fully charged tablet would last a shift but when given to the oncoming shift it would require charging at some point. Her IPAD died a few times on her shift and she notified the other staff to alert her if a door alarm went off. The Director was aware and new IPADS were ordered a while ago. Door alerts failed to appear on the IPAD a couple of times and she thought management had knowledge of this issue. The door on Tenant #C1's door failed to work properly and would alarm even when the door was shut. She informed the previous maintenance man sometime before Christmas but he is no longer employed. Hourly safety were required in the memory care unit to ensure everyone is accounted for and she received re-training on the door alarm policy and visual checks.

On 1-24-22 at 3:31 p.m. Staff F reported the following:
She worked in the memory care unit and Tenant #C1 resided in memory care for a few years. An alarm had been placed on her apartment door approximately one and half years ago and had an

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ankle monitor applied approximately one year ago. Tenant #C1 required these for her safety due to a history of elopement attempts and occurred more often on the 2 p.m. to 10 p.m. shifts due to her preference to sleep in. It would not be unusual for Tenant #C1 to move her belongings into the hallway in an attempt to leave and she required enhanced supervision and safety checks to be documented when completed. Tenant #C1's apartment door alarm worked as long as the door remained shut. Tenant #C1 preferred to keep the door open, would regularly go in/out of her apartment, and this resulted in a continuous alarm.

On 2-1-22 at 3:21 p.m. Staff G confirmed the door alerts failed to appear on the IPAD at times and reported this to the Executive Director on 12-28-21.

The Executive Director (ED) revealed the following:
*On 1-24-22 at 12:55 p.m. she stated Tenant #C1 resided near the exit where staff found her. She received doors alerts on her phone via text message the East Garden Door and Tenant #C1's apartment door were breached but she failed to hear them because she was asleep. The text alert on her phone was difficult to hear and it failed to wake her up. Screenshots of her phone revealed she received the first alert at 9:44 p.m. on 1-20-22 for the East Garden Door and continued to receive them every five minutes and door alerts for Tenant #C1's apartment door alarm every 5 minutes from around 4:30 p.m. 1-20-22 until early morning 1-21-22.

*On 1-25-22 at 11:32 a.m. she confirmed Tenant #C1 propped her door open frequently and allowed the alert to go off continuously. She

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stated she failed to check on it each time because it occurred often.

*On 1-26-22 at 9:46 a.m. two staff informed her they had issues with the IPADs not working properly during an elopement drill on 12-28-21. The IPAD 's failed to make noise and the system for the door alarms didn't always work. She assumed staff turned down the volume at times and failed to hear the alert. On 1-21-22 the Clinical Educator checked every IPAD and found no issues. New IPADs were ordered prior to the elopement drill. The Healthcare Coordinator covered the on-call duties on 1-20-22 and didn't know why she failed to respond to the door alerts. Tenant #C1 required a door alarm for her safety and the door alarm failed to work properly for over one month. Staff reported the door alarmed constantly at times even when the door was shut. The alarm was installed with double sided tape, continued to slip out of alignment, and failed to have it securely installed to prevent this from happening.

*On 1-26-22 at 1:22 p.m. she confirmed the door must be shut to clear and reset the alarm on Tenant #C1's door.

On 1-25-22 at 9:37 a.m. the Portfolio Leader confirmed the Program recognized the need to develop a new system to alert management by a phone call instead of text to ensure they hear the alert, discussed installing a different type of exit doors, and purchased new camera systems to record 24 hours a day in all areas to be installed immediately.

On 1-26-22 at 10:00 a.m. this surveyor and the Senior Portfolio Leader stood in the TV room and adjusted the volume on the TV to a moderate

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level. The Executive Director walked to the East Garden Door to open it and set off the alarm. This surveyor heard a faint alarm and confirmed with the Senior Portfolio Leader if the TV volume was increased and the staff engaged in loud conversation with the tenant present around 9:30 p.m., the alarm may not have been heard.

On 2-2-22 at 11:54 a.m. the Registered Nurse (RN) reported the following:
She worked 1-20-22 as the on-call nurse that evening and noticed the on-going door alerts for Tenant #C1 on her work phone. She failed to respond to them due to being with her family and was in bed around 9:30 p.m. She ignored the alerts in the past because Tenant #C1 opened the door constantly. The Program provided no training related to monitoring the phone for the door alerts and stated that wasn't part of the on-call expectations per the Executive Director. The expectation was to answer phone calls from staff and not to monitor the phone while on-call. Staff received door alerts to their IPADs and she expected them to watch for them and felt that wasn't something she needed to monitor. Tenant #C1 required an alarm on her apartment door due to wandering and exit seeking behavior and often got into other tenants belongings. Staff reported door alerts failed to come through the IPAD at times and new IPADs were ordered some time ago. She should have called the staff to check on things but assumed the staff would take care of it. She delegated all staff on visual checks, door alarms, and POC during a skills fair in November 2021. They understood the training and signed the paperwork acknowledging competency. She delegated Staff A one on one and signed off on the training.

On 2-2-22 at 3:37 p.m. the Clinical Care

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A 635	Continued From page 55 Coordinator stated she completed a Quality Assurance review with the RN on 12-20-21 and included to "continue to monitor Pendant and Security Response times-Escalating Call". She explained the Escalating Call sent the door alerts to the cell phones provided to the Director and Nurse to monitor as part of their job. The Senior Portfolio Leader confirmed these findings on 3-14-22 at 3:10 p.m.	A 635		
A 705	481-69.35(1)a Structural Requirements 69.35(1) General requirements. a. The structure of the program shall be designed and operated to meet the needs of the tenants. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to operate to meet the needs of the tenants for 1 of 1 discharged tenants reviewed (Tenant #C1) as a result of 101735-I and potentially affected all tenants in the memory care unit. Findings follow: 1. Record review of Tenant #C1's file on 1-25-22 revealed the following: Incident Report dated 1-21-22 revealed at approximately 6:19 a.m. the Registered Nurse (RN) received a call from Staff B who reported Tenant #C1 was found outside of the East Garden Door in the memory care unit. Staff brought her inside and covered her with blankets and immediately called 911. They reported she	A 705		

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failed to respond but then found a pulse. Emergency services arrived and transported Tenant #C1 to the hospital. Around 8:55 a.m. the Sheriff arrived to investigate and informed the Program Tenant #C1 passed away at the hospital. Staff noted she wore long pants, a sweater, and shoes with the temperature noted to be around 7 degrees below zero.

The Service Plan dated 11-13-21 revealed she required assistance with activities, bathing, toileting, medications, and received hospice services. Continued review noted forgetfulness, mild to moderate disorientation, difficulty retaining information, wore a wanderguard for added safety, and required hourly safety checks. Further review revealed diagnoses of Alzheimer's disease, major depressive disorder, and anxiety disorder.

The Global Deterioration Scale completed 8-13-21 revealed a score of 5 and indicated moderately severe cognitive decline.

A 90 Day Review dated 11-13-21 revealed she continued to have episodes of anxiety, packed up her room, and attempted to leave the community. She exit seeked and wandered at times of high anxiety and had PRN (as needed) medications to assist with behavior and had been effective. A Century System had been placed on her apartment door to assist with monitoring and had been effective this quarter with no elopements.

2. Documents and surveillance video provided by the Program confirmed the following:

Documentation Survey Reports revealed Staff A failed to complete and document hourly safety checks on December 28, 2021 at 10:00 p.m. until

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A 705	Continued From page 57 December 29, 2021 at 6 a.m., December 29, 2021 at 10:00 p.m. until December 30, 2021 at 6 a.m, and January 20, 2022 at 10:00 p.m. until January 21, 2022 at 6 a.m. Device Activity Report revealed E5 East Garden Door alarmed at 9:34 p.m. on 1-20-22 until cleared at 6:12 a.m. on 1-21-22. Tenant #C1's door alarmed at 4:23 p.m. on 1-20-22 until cleared at 7:15 a.m. on 1-21-22. On 1-20-22 video footage recorded Staff A arriving after 10 p.m. Continued review showed her walking around the unit from approximately 11:09 p.m. until 2:44 a.m. and failed to walk down the east hallway to complete safety checks. A male tenant walked around the unit and appeared to fall asleep in a chair. Further review revealed around 2:44 a.m. until 6:10 a.m. she continued to walk around the memory care unit. She walked over to the assisted living area two times, and walked past the sleeping male tenant several times. She failed to walk down the east hallway throughout the night to complete hourly checks as required. 3. Record review of the hospital's emergency room documentation revealed Tenant #C1 arrived at 7:23 a.m. on 1-21-22. The Pre-Arrival Summary noted the chief complaint to be "hypothermia, cold, stiff, ice freezing on her, responsive to pain, head and hand abrasion". Further review revealed en route her pulse was 40 beats per minute and when pulse was lost, EMS (Emergence Medical Services) performed CPR for approximately 90 seconds. Upon arrival at the hospital, EMS noted a slight pulse and when brought in to the emergency room, no pulse could be obtained. EMS stated she was too cold to obtain a temperature. Continued review	A 705		

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revealed her temperature to be around 25 degrees Celsius (77 degrees Fahrenheit). Family was contacted and determined efforts to be ceased due to lack of expected meaningful recovery. The diagnosis was cardiac arrest and hypothermia and Tenant #C1 was deceased.

4. Record review of Polk County Medical Examiners Report of Autopsy documented pathologic diagnoses included heart failure and hypothermia due to cold exposure. Tenant #1's cause of death was documented as hypothermia (minutes) due to environmental cold exposure (hours) and the manner of death was documented as an accident.

5. According to the state climatologist the weather in Bondurant on 1-20-22 around 6:19 a.m. was -11 degrees Fahrenheit with relative humidity of 76%, the sky was clear, and the wind was calm with no windchill.

6. Record review on 1-31-22 of the Program's policy and procedures and job descriptions confirmed the following:

The Elopement Policy stated routine visual checks would be completed on tenants with confusion at or above Stage 4 on the Global Deterioration Scale. For tenants at risk of wandering, a Sentry System may be installed in individual apartments. If a tenant exited their apartment an emergency call would be activated to notify staff to check on the tenant. The system included visual checks eight times per shift. Staff were to watch for signs of wandering and confusion that may put the tenant at risk of elopement and if an exit door alarm sounds they should thoroughly check inside and outside areas triggered by the alarm.

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A 705	Continued From page 59 Nurse Delegation for Door Alarm Response revealed as staff received a notification to their IPAD of a door breached or opened, staff should immediately go to that door and observe inside and outside that door to find out who utilized the door. After knowing who used the door staff could push the green button, enter the code, on IPAD, etc to reset the door. The procedure included the alarms were in place to keep tenants safe. Ex. If a tenant exhibited increased confusion they may exit the community in inclement weather without being properly clothed. Nurse Delegation for Point of Care, EMAR or Companion revealed staff logged into program with individualized and confidential login information. Staff selected the specific program for correct documentation and review required tasks. Staff logged out after ensuring all tasks had been completed to prevent use from an unauthorized person. Community Manager job summary revealed the Director is on call 24/7 and maintained normal business hours 8 a.m. to 5 p.m. Monday through Friday. The Director's role included to ensure resources were in place to deliver quality essential services, to assure quality workmanship and performance was achieved by on-site staff. Continued review revealed Operational and Emergency Monitoring included to assure 24/7 coverage to carry on daily operational services and needs. Healthcare Coordinator Essential Functions included to coordinate and implement the delivery of tenant care and to assure 24/7 coverage to respond to calls for urgent assistance from tenants of the Community, respond to fire alarms	A 705		

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A 705	Continued From page 60 or other emergencies, and other duties as assigned. 7. Record review of staff files on 1-31-22 revealed the following: Staff A signed the Elopement Policy on 6-9-21, the Nurse Delegation for Door Alarm Response, Visual Checks, and Point of Care delegations on 11-22-21, and acknowledged she was competent to complete the task as trained. On 1-3-22 she received a verbal warning over the phone from the LPN for failure to document tasks performed on her shift in Point Click Care on 12-30-21 as required. Corrective action included timely charting during her shift to reflect the cares provided to the tenants. On 1-28-22 the Program mailed a letter of termination effective 1-21-22. Staff B signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-21-22 she received a written warning for failure to respond to door alarms as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants. Staff C signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-21-22 she received a written warning for failure to respond to door alarms as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants. Staff D signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete	A 705		

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the task as trained. On 1-25-22 she received a written warning for failure to respond to door alarms and failure to carry an IPAD as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants.

Staff E signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-25-22 she received a written warning for failure to respond to door alarms and failure to carry an IPAD as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants.

8. Staff interviews revealed the following:

On 2-1-22 at 11:30 a.m. Staff A revealed the following:
She started about six months ago and confirmed the Program provided training for safety checks and door alarms. Two staff usually worked in the memory care unit overnight and on 1-20-22 she was the only staff and Staff B worked in the assisted living area. She stated a male tenant yelled, banged, and attempted to exit the memory care unit at times that kept her busy throughout the entire shift. He wasn't wearing a jacket and required constant supervision to prevent him from going outside the door in the lounge area for most of her shift.

Her IPAD was in the TV room and another IPAD was in the laundry room. The door alerts failed to appear on either IPAD. She provided a screen shot that revealed she texted the Executive Director in December 2021 the door alarm failed to show up on her tablet.

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A 705	Continued From page 62 Around 4 or 5 in the morning Staff B arrived and stated the computer showed the door alarm going off. She dropped everything, searched the area,and found Tenant #C1 outside the exit door in the East Hallway. Both staff brought her in and covered her with blankets and immediately called 911. She observed clothing hung and draped on the handrail and a purse near Tenant #C1. She confirmed knowledge of the camera located in the lounge above the exit door that recorded 24 hours per day and continued to state she worked on laundry and provided supervision to the male tenant throughout her shift. She confirmed Tenant #C1 required an alarm on her apartment door because "she can leave and had a history of doing it" and stated "it is very important to check and make sure they are safe". The previous staff informed her everyone was ok and tenants were in their rooms and did not see Tenant #C1 at this time. She observed Tenant #C1's door was shut and failed to explain how she knew the door was shut when the video revealed she never walked down Tenant #C1's hallway. She failed to do rounds to check each tenant hourly as trained and continued to insist the male tenant required her full attention for the entire shift and prioritized keeping him from exiting the building. This surveyor explained the video failed to match how she described her shift and revealed the male tenant asleep around 2:53. She stated she remained in the TV room from 3:32 am to 5:23 a.m. and peaked her head out to make sure he was ok. She prioritized monitoring the male tenant because the door alarms failed to show up on the tablet at times. She stated it "slipped my mind to do safety checks" down the east hallway. She checked on one tenant in the west hallway to	A 705		

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A 705	Continued From page 63	A 705		

ensure the door was closed to prevent her from waking up from the noise the male tenant made. She stated "it did not come to my mind honestly to check on Tenant #C1" after she acknowledged the issue with the door alerts, that Tenant #C1 required a door alarm for her safety due to wandering, and Tenant #C1 slept lightly.

On 1-25-22 at 10:38 a.m. Staff B reported the following:
She arrived at the memory care unit around 10 p.m. on 1-20-22 and started to sanitize the equipment. Staff A arrived and wanted to work in the memory care unit so she walked back to the front to work in the assisted living part of the building. No door alert appeared on her IPAD when she opened it. The IPAD's battery died before the end of her shift and went to the office for a replacement. She noticed the desktop computer monitor had door alerts for the East Garden door and Tenant #C1's apartment door. She walked to the memory care and observed Staff A in the laundry room. She told her she was checking the alarms and Staff A did not respond. She observed Tenant #C1's apartment door was open, checked inside, and yelled to Staff A "she is not in her room". Staff A arrived and both went to the exit door near her apartment. She observed Tenant #C1's clothing on the handrail and saw shoes when she opened the exit door. Both staff moved Tenant #C1 inside and got blankets to cover her. She called the Healthcare Coordinator and received instructions to call 911. Tenant #C1 made some noise but was unresponsive. Tenant #C1 wore a sweater, pants, shoes, but no coat, hat, or gloves. EMS arrived for Tenant #C1 and as they left she observed Tenant #C1 open her eyes as they exited the building. Tenant #C1 had a history of being up and down throughout the night and asked about the location of stairs,

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A 705	Continued From page 64	A 705		

elevators, her dog, or her car. She attempted distractions to redirect Tenant #C1 when this occurred and attempted to keep her in her sight due to her history of exit seeking. The memory care residents required hourly checks with eyes on the person to confirm their presence and documented when they are done. The past few weeks Tenant #C1's door alarm continued to send alerts even when closed and at times the IPAD failed to receive door alerts once in while. She assumed the Assistant Director knew about the issue with Tenant #C1's alarm but not sure if she knew about the issues with the IPAD.

On 1-24-22 at 2:17 p.m. Staff C stated the following:
The exit door in the memory care unit had an audible alarm and she would be able to hear it if in the area but reported it may be hard to hear if staff were busy with other tenants or in an apartment. Staff relied on the IPAD to notify them of door alarms. During shift change no one acknowledged a door alert and Tenant #C1 remained in the TV room and she left after 10 p.m. Hourly checks are required to be done and documented on each tenant. The door alarm system "Ariel" alerts failed to appear on the IPADS occasionally and informed the previous Director of the issue. Other staff talked about this issue and new IPADs had been ordered by the new Director. The door alarm on Tenant #C1's door alarmed even when shut and had done so for at least one month. The alarm appeared on the IPAD and no one cleared it due to the continuous alarm. All staff knew the door alarm failed to work properly and the issue was discussed at team meetings. The maintenance man failed to fix the issue before he left employment. She failed to have a charged IPAD with her as required and did not think to check all

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exit doors knowing the IPAD failed to receive alerts on occasion. She assumed Tenant #C1 may have tried to open the exit door by her apartment prior to coming to the TV room.

On 1-24-22 at 3:55 p.m. Staff D reported the following:
She knew Tenant #C1's apartment door alarm failed to work properly and alarmed every two minutes. At first staff checked every time but as it continued, the staff checked the hallway once in a while due to the continuous alarm.

On 1-25-22 at 3:42 p.m. Staff D confirmed she knew neither staff in the memory care unit carried a charged IPAD and assumed responsibility to notify them if anything appeared on her IPAD. This occurred often and the only alert she observed was Tenant #C1's apartment door alarm every 2 minutes. There had been issues with "Ariel" and alerts failed to come through to the IPAD once in a while.

On 1-25-22 at 1:07 p.m. Staff E stated the following:
She gave her IPAD to Staff G who worked on the assisted living side and Staff C's battery died and was on the charger. At least one person on the shift was required to have an IPAD at all times. Four IPADS were available when fully charged and only 2 chargers worked currently. A fully charged tablet would last a shift but when given to the oncoming shift it would require charging at some point. Her IPAD died a few times on her shift and she notified the other staff to alert her if a door alarm went off. The Director was aware and new IPADS were ordered a while ago. Door alerts failed to appear on the IPAD a couple of times and she thought management had knowledge of this issue. The door on Tenant

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#C1's door failed to work properly and would alarm even when the door was shut. She informed the previous maintenance man sometime before Christmas but he is no longer employed. Hourly safety were required in the memory care unit to ensure everyone is accounted for and she received re-training on the door alarm policy and visual checks.

On 1-24-22 at 3:31 p.m. Staff F reported the following:
She worked in the memory care unit and Tenant #C1 resided in memory care for a few years. An alarm had been placed on her apartment door approximately one and half years ago and had an ankle monitor applied approximately one year ago. Tenant #C1 required these for her safety due to a history of elopement attempts and occurred more often on the 2 p.m. to 10 p.m. shifts due to her preference to sleep in. It would not be unusual for Tenant #C1 to move her belongings into the hallway in an attempt to leave and she required enhanced supervision and safety checks to be documented when completed. Tenant #C1's apartment door alarm worked as long as the door remained shut. Tenant #C1 preferred to keep the door open, would regularly go in/out of her apartment, and this resulted in a continuous alarm.

On 2-1-22 at 3:21 p.m. Staff G confirmed the door alerts failed to appear on the IPAD at times and reported this to the Executive Director on 12-28-21.

The Executive Director (ED) revealed the following:
*On 1-24-22 at 12:55 p.m. she stated Tenant #C1 resided near the exit where staff found her. She received doors alerts on her phone via text

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message the East Garden Door and Tenant #C1's apartment door were breached but she failed to hear them because she was asleep. The text alert on her phone was difficult to hear and it failed to wake her up. Screenshots of her phone revealed she received the first alert at 9:44 p.m. on 1-20-22 for the East Garden Door and continued to receive them every five minutes and door alerts for Tenant #C1's apartment door alarm every 5 minutes from around 4:30 p.m. 1-20-22 until early morning 1-21-22.

*On 1-25-22 at 11:32 a.m. she confirmed Tenant #C1 propped her door open frequently and allowed the alert to go off continuously. She stated she failed to check on it each time because it occurred often.

*On 1-26-22 at 9:46 a.m. two staff informed her they had issues with the IPADs not working properly during an elopement drill on 12-28-21. The IPAD 's failed to make noise and the system for the door alarms didn't always work. She assumed staff turned down the volume at times and failed to hear the alert. On 1-21-22 the Clinical Educator checked every IPAD and found no issues. New IPADs were ordered prior to the elopement drill. The Healthcare Coordinator covered the on-call duties on 1-20-22 and didn't know why she failed to respond to the door alerts. Tenant #C1 required a door alarm for her safety and the door alarm failed to work properly for over one month. Staff reported the door alarmed constantly at times even when the door was shut. The alarm was installed with double sided tape, continued to slip out of alignment, and failed to have it securely installed to prevent this from happening.

*On 1-26-22 at 1:22 p.m. she confirmed the door

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must be shut to clear and reset the alarm on Tenant #C1's door.

On 1-25-22 at 9:37 a.m. the Portfolio Leader confirmed the Program recognized the need to develop a new system to alert management by a phone call instead of text to ensure they hear the alert, discussed installing a different type of exit doors, and purchased new camera systems to record 24 hours a day in all areas to be installed immediately.

On 1-26-22 at 10:00 a.m. this surveyor and the Senior Portfolio Leader stood in the TV room and adjusted the volume on the TV to a moderate level. The Executive Director walked to the East Garden Door to open it and set off the alarm. This surveyor heard a faint alarm and confirmed with the Senior Portfolio Leader if the TV volume was increased and the staff engaged in loud conversation with the tenant present around 9:30 p.m., the alarm may not have been heard.

On 2-2-22 at 11:54 a.m. the Registered Nurse (RN) reported the following:
She worked 1-20-22 as the on-call nurse that evening and noticed the on-going door alerts for Tenant #C1 on her work phone. She failed to respond to them due to being with her family and was in bed around 9:30 p.m. She ignored the alerts in the past because Tenant #C1 opened the door constantly. The Program provided no training related to monitoring the phone for the door alerts and stated that wasn't part of the on-call expectations per the Executive Director. The expectation was to answer phone calls from staff and not to monitor the phone while on-call. Staff received door alerts to their IPADs and she expected them to watch for them and felt that wasn't something she needed to monitor. Tenant

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A 705	Continued From page 69 #C1 required an alarm on her apartment door due to wandering and exit seeking behavior and often got into other tenants belongings. Staff reported door alerts failed to come through the IPAD at times and new IPADs were ordered some time ago. She should have called the staff to check on things but assumed the staff would take care of it. She delegated all staff on visual checks, door alarms, and POC during a skills fair in November 2021. They understood the training and signed the paperwork acknowledging competency. She delegated Staff A one on one and signed off on the training. On 2-2-22 at 3:37 p.m. the Clinical Care Coordinator stated she completed a Quality Assurance review with the RN on 12-20-21 and included to "continue to monitor Pendant and Security Response times-Escalating Call". She explained the Escalating Call sent the door alerts to the cell phones provided to the Director and Nurse to monitor as part of their job. The Senior Portfolio Leader confirmed these findings on 3-14-22 at 3:10 p.m.	A 705		

Courtyard Estates Hawthorne Crossing
601 Hawthorne Crossing Dr SE
Bondurant, IA 50035

Date: March 23, 2022

Complaint/Investigation Intake #'s: Complaint 101714-A, Incident 101735-M, Complaint 101794-A, Complaint 102066-C

Plan of Correction (POC) Submitted For:

- Recert or Investigation Date: 1/24/2022 to 3/14/2022
-

POC:

- **A 150 481-67.2(3) Program Policies and Procedures: The program shall follow the policies and procedures established by the program.**
    - **Regulatory Insufficiency:** *Program failed to follow its policies and procedures as established for 2 of 9 discharged tenants reviewed.*
    - **Program POC:**

1. Elements detailing how the insufficiency was corrected.

Corporate clinical nurses provided re-education and re-delegated all staff tasked with caring for tenants on the following:

- Elopement Policy
- Door Alarm Response
- Pendant Response
- Visual Checks

New iPads were purchased and tested to ensure alarms were working as expected.

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

Care staff will receive education and be delegated during their orientation, annually and on an as needed basis on the following:

- Elopement Policy
- Door Alarm Response
- Pendant Response
- Visual Checks

Ensuring the iPads are working correctly will be conducted Weekly, monthly, or as determined by the director.

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

Pendant and Door Alarm Response reports will be pulled on a weekly basis for compliance review by the Program Director or designee for 6 weeks and then periodically as determined by designee. Any discrepancies will be noted, and appropriate education/coaching will be completed.

- **A 160 481-67.3(2) <u>Tenant Rights</u>: All tenants have the following: To receive care, treatment and services which are adequate and appropriate.**

    - **<u>Regulatory Insufficiency:</u>** *Program failed to provide adequate and appropriate care, treatment, and services to 2 of 9 discharged tenants reviewed.*
    - **<u>Program POC:</u>**

        1. **Elements detailing how the insufficiency was corrected.**
           Corporate clinical nurses provided re-education and re-delegated all staff tasked with caring for tenants on the following:
           - Elopement Policy
           - Door Alarm Response
           - Pendant Response
           - Visual Checks

           New iPads were purchased and tested to ensure alarms were working as expected.

        2. **Measures taken to ensure the problem does not recur.**
           Care staff will receive education and be delegated during their orientation, annually and on an as needed basis on the following:
           - Elopement Policy
           - Door Alarm Response
           - Pendant Response
           - Visual Checks

           Ensuring the iPads are working correctly will be conducted Weekly, monthly, or as determined by the director.

        3. **How the program plans to monitor performance to ensure compliance.**
           Pendant and Door Alarm Response reports will be pulled on a weekly basis for compliance review by the Program Director or designee for 6 weeks and then periodically as determined by designee. Any discrepancies will be noted, and appropriate education/coaching will be completed.

- **A 395 481-69.26(4)a <u>Service Plans</u>: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences.**

    - **<u>Regulatory Insufficiency:</u>** *Program failed to develop an individualized service plan to indicate identified needs and preferences for assistance for 1 of 9 discharged tenants reviewed.*
    - **<u>Program POC:</u>**

        1. **Elements detailing how the insufficiency was corrected.**
           Service plans on current residents have been reviewed by nursing staff to ensure that all needs/preferences are accurately listed on ISP.

        2. **Measures taken to ensure the problem does not recur.**
           Service plans are reviewed with all assessments completed.
           Continuing nursing education for nursing staff on service plan completion and accuracy.

3. **How the program plans to monitor performance to ensure compliance.**
Maintenance coordinator and/or designee will complete weekly checks on door alarm systems and will follow up with nurse after checks to ensure that ISP is current.

- **A 530 481-9.29(4) <u>Staffing</u>: Staffing. A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans.**
A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan.
The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans.

    - **<u>Regulatory Insufficiency:</u>** *Program failed to monitor tenants as indicated in the service plans for 2 of 9 discharged tenants reviewed and potentially affected all tenants in the memory care unit.*
    - **<u>Program POC:</u>**

1. **Elements detailing how the insufficiency was corrected.**
Corporate clinical nurses provided re-education and re-delegated all staff tasked with caring for tenants on the following:
    - Elopement Policy
    - Door Alarm Response
    - Pendant Response
    - Visual Checks

New iPads were purchased and tested to ensure alarms were working as expected.

2. **Measures taken to ensure the problem does not recur.**
Care staff will receive education and be delegated during their orientation, annually and on an as needed basis on the following:
    - Elopement Policy
    - Door Alarm Response
    - Pendant Response
    - Visual Checks

    Ensuring the iPads are working correctly will be conducted Weekly, monthly, or as determined by the director.

3. **How the program plans to monitor performance to ensure compliance.**
Pendant and Door Alarm Response reports will be pulled on a weekly basis for compliance review by the Program Director or designee for 6 weeks and then periodically. Any discrepancies will be noted, and appropriate education/coaching will be completed.
POC reviewed weekly by nurse and/ or designee to ensure tasks are completed and documented accurately.

- **A 545 481-69.30(1) <u>Dementia Specific Education for Personnel</u>: All Personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.**

    - **<u>Regulatory Insufficiency:</u>** *Program failed to provide 8 hours of dementia training within 30 days of employment for 1 of 7 staff reviewed as a result of Incident #101735-I.*
    - **<u>Program POC:</u>**

        1. **Elements detailing how the insufficiency was corrected.**
           Staff A and B were terminated.

        2. **Measures taken to ensure the problem does not recur.**
           All new staff will have their on-line education, including the minimum eight hours of dementia-specific training scheduled as a workday to ensure completion prior to their training on the floor.

        3. **How the program plans to monitor performance to ensure compliance.**
           The Program Director, or designee, will review each new staff members dementia-specific education within thirty-days of hire to ensure compliance for six months and then periodically.

- **A 635 481-69.32(2) <u>Life Safety – Emergency Policies/Structure</u>: An operating alarm system shall be connected to each exit door in a dementia-specific program.**

    - **<u>Regulatory Insufficiency:</u>** *Program failed to ensure an operating alarm system was connected to exit doors of a dementia unit for 1 of 1 tenant reviewed as a result of 101735-I and potentially affected all tenants in the memory care unit.*
    - **<u>Program POC:</u>**

        1. **Elements detailing how the insufficiency was corrected.**
           New magnetic delayed egress door locks were installed on the memory care unit exit doors to ensure the door alarms are auditory until re-set at the keypad located next to the doors.

        2. **Measures taken to ensure the problem does not recur.**
           Door alarm checks are completed weekly by Maintenance and/or designee. Any discrepancies noted are to be reported immediately to the Program Director and/or designee.

        3. **How the program plans to monitor performance to ensure compliance.**
           The Program Director, or designee, will review the weekly door alarm checks for four weeks and then monthly to ensure compliance.

- **A 705 481-69.35(1)a <u>Structural Requirements</u>: General requirements. The structure of the program shall be designed and operated to meet the needs of the tenants.**

- **Regulatory Insufficiency:** *Program failed to operate to meet the needs of the tenants for 1 of 1 discharged tenant reviewed as a result of 101735-I and potentially affected all tenants in the memory care unit.*
- **Program POC:**

1. **Elements detailing how the insufficiency was corrected.**
   All current door alarms placed on resident doors were checked for secure placement by director/maintenance coordinator.

2. **Measures taken to ensure the problem does not recur.**
   Maintenance was instructed to secure the door alarm into the door frame with screws to ensure stability of the alarm and compliance.

3. **How the program plans to monitor performance to ensure compliance.**
   The Program Director, or designee, will visually note the installation of each door alarm for proper installation. Maintenance will conduct a monthly door alarm checks to ensure compliance.

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.