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
	S0273	A. BUILDING: _____ B. WING _____	C 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY	1801 EAST KANESVILLE BLVD CO BLUFFS, IA 51503

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A 000	Initial Comments This Program met criteria to be an Assisted Living Program for People with Dementia by definition on the last certification visit on 5/7/2024. Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 25 Number of tenants with cognitive impairment: 10 Total census: 35 No regulatory insufficiencies were cited during the investigation of Complaint #123014-C. The following regulatory insufficiencies were cited during the investigation of Incident #121513-I.	A 000		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure service plans were	A 350		

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A 350	Continued From page 1	A 350		

based on evaluations, included specific service needs, and were updated as needed for 1 of 1 former tenants reviewed (Tenant C1). Findings follow:

Record review on 11/12/24 revealed Tenant C1, age 97, was admitted to the program on 6/26/20 with a Global Deterioration Scale (GDS) score of 5 indicating moderately severe cognitive decline.

Review of an Incident Report dated 6/9/24 at 11:15 am revealed Tenant C1 eloped from the program and was stopped about a block down the street. Staff became aware after receiving phone calls from the community-at-large as well as a visitor entering the program who reported Tenant C1 was observed walking on E. Kanesville Rd. The incident report failed to indicate whether the door alarms were activated at the time of the elopement. The tenant's vital signs were taken at 11:35 am upon her return and were within normal limits. No injuries were noted.

When interviewed on 11/12/24 at 1:45 pm, the Executive Director stated the doors were not alarmed during the hours of 7:00 am to 7:00 pm and staff would not have been alerted if someone had exited the building on the date/time of the elopement. A summary of the program's internal investigation and review of camera footage by program staff revealed Tenant C1 exited through the front door of the program at approximately 10:30 am on 6/9/24.

On 11/19/24 at 10:00 am the State Climatologist stated the temperature at the time of the elopement was 78-80 degrees Fahrenheit with fair conditions and no precipitation. Winds were out of the NW to WNW at 7-12 miles per hour (mph), with gusts up to 21 mph. Iowa Traffic Data

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A 350	Continued From page 2	A 350		

from the Iowa Department of Transportation revealed a total average annual daily traffic on E. Kanesville Rd/Hwy 906 as 10,000 vehicles.

When interviewed on 11/14/24 at 8:33 am, the responding officer from the Council Bluffs police department stated he was in the area and had been stopped at a light on 6/9/24 when community members verbally reported to him an elderly woman was in the middle of E. Kanesville Rd. The officer stated he immediately made a U-turn and began to head in the direction of the reported incident when an additional call came through his dispatch. When he arrived on scene, he observed Tenant C1 in the middle of the road. Vehicles were stopped and people were attempting to offer aide to the tenant. He stated Tenant C1 was unharmed but he could tell she was confused and stated two program staff were running towards the area.

When interviewed on 11/12/24 at 11:50 am, Staff A stated she worked on the day of the elopement. She had received a phone call from someone in the general public who reported there was a lady out on the highway. Progress notes from Staff A revealed the call came in to the program at approximately 11:15 am. Staff A further stated during the interview she immediately thought of Tenant C1 and went to her apartment but could not locate her. Staff A then received a verbal report from the daughter of another tenant who was entering the building and believed she observed Tenant C1 out on the highway. Staff A paged staff for assistance as she headed towards the front entrance along with another staff member who joined them. By the time she reached the front part of the campus grounds and looked down the highway, traffic had been stopped and a police officer was in the process of

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A 350	Continued From page 3	A 350		

transporting Tenant C1 back to the building. Staff A stated Tenant C1 normally had confusion and had exhibited wandering behavior before, but usually exited out a side door. Tenant C1 had just exited from the program out the side door a few days prior.

On 11/13/24 at 3:45 pm, Staff C stated she had just received the nurses page for assistance on 6/9/24 when she also received a phone call from someone in the community-at-large who reported a woman out on the highway. Staff C made her way downstairs to 1st floor and then met other responding staff members who then all went out the front door. She saw activity down the street more than a block away and saw the police.

Review of an incident report dated 6/7/24 revealed Tenant C1 was observed outside of an exit door area by room 126. She stated she didn't know where/why she was there but was redirected back inside without difficulty.

Staff C stated during her interview on 11/13/24 she had been instructed to complete 15-minute checks after the incident on 6/7/24, but was unaware of any additional interventions or hourly checks prior to the elopement on 6/9/24. Staff C stated she felt Tenant C1 had started to wander a little bit more. She indicated other staff mentioned Tenant C1 previously sat outside and then came back in the building, but she noticed as time went on Tenant C1 started to wander farther away from the doors. She recalled one time (no date specified) Tenant C1 wandered all the way to the trash area and she had to go get her and bring her back in. Staff C stated she knew of no interventions put into place to help address the increased wandering behavior.

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A 350	Continued From page 4 When interviewed on 11/12/24 at 12:10 pm Staff D stated when she started employment earlier in the year she had observed Tenant C1 outside on occasion. She questioned if the tenant was safe to be outside on her own, and was told she was. She had noticed Tenant C1 had increased confusion leading up to the elopement incident on 6/9/24. Review of a 6 month evaluation dated 2/26/24 revealed Tenant C1 had poor recent mental health status and required regular prompting due to confusion and disorientation. The elopement risk section of the evaluation indicated Tenant C1 hallucinated and/or looked for individuals that were not present, had disorientation and intermittent confusion, purposelessly wandered, and had a history of elopement. Tenant C1's service plan, last updated 2/26/24, had a need area regarding Orientation/Prompting in which staff where to orient and prompt her as necessary. Under the Safety/Risk category, the tenant had need areas for Fall Risk Assistance and Evacuation Assistance if needed. The service plan did not address the tenant's wandering behaviors and interventions or her history of elopement as noted in the 6 month evaluation completed on 2/26/24. In addition, the program failed to revise the service plan to include interventions after repeated episodes of wandering outside of the building as noted by staff. On 11/14/24 at 1:00 pm the Nursing Director and Executive Director confirmed the above findings.	A 350	Home Office Executives are currently reconfiguring software settings in the electronic health record system for the conversion from the assessments to the service plans to ensure compliance with regulatory requirements. This reconfiguration will affect all areas in the assessment. Configuration of the software to be complete by 3/28/25. & Assessments to be updated following the reconfiguring updates on all residents with wandering assistance/ intervention needs by 4/9/25 to meet the regulatory requirement.	
A 430	481-69.27(1)c Nurse Review	A 430		

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A 430	Continued From page 5 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete nurse reviews every 90 days. This pertained to 1 of 1 discharged tenants reviewed (Tenant C1), with the potential to adversely affect all tenants residing in the program. Findings follow: Record review on 11/12/24 revealed Tenant C1 admitted to the program on 6/26/20. Further review on 11/13/24 revealed the program Nursing Director (RN) last completed an Evaluation for Tenant C1 entitled "6-month Eval" on 2/26/24 and had begun, but not completed, a Change of Condition Evaluation on 6/9/24. The provided documentation from the program lacked a required quarterly nurse review for Tenant C1 in May of 2024. When interviewed on 11/14/24 at 10:15 am, the Nursing Director stated there was no quarterly nurse review for Tenant C1 and further stated the program had not completed quarterly nurse reviews for any tenants residing at the program as the program had been instructed quarterly	A 430	Effective November 14, 2024 a Periodic/Monthly Summary was added to resident compliance in the electronic health record. & As of February 28, 2025 this was completed for all Assisted Living residents. An expiration date added ensuring this will trigger to be completed for each resident quarterly. Audits to be completed nightly (24° chart check) to ensure compliance rates of 100% in electronic health record. Audit report submitted to DON daily. Audits will further be reviewed monthly at QAPI.	

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A 430	Continued From page 6 nurse reviews were not necessary according to their management company. On 11/14/24 at 1:00 pm the Nursing Director and Executive Director confirmed the above findings.	A 430		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the program failed to ensure an operating door alarm system was connected to each exit door in the dementia-specific program. Findings follow: On 11/13/24 at 1:30 pm, the Executive Director stated the program met the definition of a dementia-specific assisted living program based off of their previous two sequential certification surveys. A review of program documentation further revealed the program served fewer than 55 tenants (a total of 35 tenants) and had 5 or more tenants (a total of 10 tenants) who had dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS) which also met the definition of a dementia-specific program. Observations throughout 11/12/24 to 11/14/24 revealed the fire doors separating the Independent Living (IL) from the Dementia-Specific Program (ALP/D) on both 1st and 2nd floors of the building had no alarm system and were held open by magnetic locks,	A 635	Effective January 15, 2025 both the Assisted Living and the Independent Living main entrances alarms' were turned on around the clock by our Home Office. PMT to complete monthly door alarm audit- immediately addressing and documenting any noted issues. Audit will be reviewd monthly during QAPI. All staff have been trained and educated on the door alarm policy and response to triggered door alarms.	

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A 635	Continued From page 7 allowing for tenants, staff and visitors to travel freely between the designated areas. Additionally, tenants, staff, and visitors were able to exit the ALP/D area of the program through the back door (ALPD entrance/exit) without an operating alarm system. During an interview on 11/12/24 at 11:40 am Staff E stated the front door (IL entrance/exit) and the back door (ALPD entrance/exit) were locked preventing people from entering, but were unlocked/unalarmed/turned off allowing people to exit during certain hours of the day and/or could be turned off when tenants moved in/out. During an interview on 11/12/24 at 11:50 am Staff A stated the front (IL) and back (ALP/D) entrance/exits weren't alarmed during the hours of 7:00 am to 7:00 pm and anyone could exit during those times without staff being alerted. During an interview on 11/12/24 at 12:10 pm Staff D stated anyone could exit either door without it alerting staff until 7:00 pm when the door alarms were then turned on. During an interview on 11/13/24 at 3:00 pm, Staff B confirmed the area of the ALP/D and the IL and confirmed the fire doors on both floors between the designated areas were usually open. During an interview on 11/13/24 at 3:45 pm, Staff C stated the front and back entrance/exits had alarm systems but were turned off and therefore didn't alert staff between the hours of 7:00 am and 7:00 pm because so many people come and go during the day and because a lot of management staff was up front during the work day.	A 635		

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A 635	Continued From page 8 On 1/14/24 review of the program's policy entitled "Door Alarm System - Assisted & Independent Living" with an effective date of 8/17/21 revealed the following: - It is a Primrose directive that all doors currently mechanically equipped to do so will be alarmed to alert egress but not to delay egress. - The policy applied to all exterior doors of the Main building, excluding memory care. - All main entrances (front and back) of the Assisted Living/Independent living Primrose Communities will be locked entering and unalarmed/unlocked exiting from 0700-1900 (7:00 am to 7:00 pm) and all other doors to the Assisted/Independent Living Community will be locked and alarmed 24/7. No further policies regarding door alarm systems related to memory care/dementia-specific programs were provided by the program. When interviewed on 11/14/24 at 10:15 am, the Nursing Director stated the doors were alarmed and the alerts went to the staff phones with the exception of the front and back entrances which were turned off during the hours of 7:00 am to 7:00 pm. In addition, the fire doors on both first and second floors separating the designated areas were usually open and had no alarm operating system. On 11/14/24 at 1:00 pm the Nursing Director and Executive Director confirmed the above findings.	A 635		