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
	S0350	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MEMORY LANE	100 BOLGER DRIVE FAYETTE, IA 52142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 0 Number of tenants with cognitive impairment: 10 Total census: 10 No regulatory insufficiencies were cited during the investigation of Complaint #125063-C. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia and the investigation of Incident #122379-I.	A 000		
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 observations, interviews, and record reviews, the Program failed to follow established policies and procedures including those for the Delayed Exit Code Alarm System, Electrical Outage, and Falls with Possible Head Injury. This directly affected 5 of 5 tenants reviewed (Tenants #1, #2, #3, #4 and #5) and potentially affected all 10 tenants living in the Program. Findings include:	A 150	The Plan of Correction is attached.	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 150	Continued From page 1	A 150		

1). On 12/2/24 a review of Tenant #2's record revealed a diagnosis of dementia with a GDS score of 5 which indicated moderately severe cognitive decline. A review of Tenant #2's incident reports revealed on 7/15/24 the tenant eloped from a locked and alarmed door of the Program during a power outage which released the door's locking mechanism and main alarm at approximately 5:45 pm. She was found in the parking lot looking for her car by staff from the adjoining nursing home. The tenant was wearing a shirt, pants, and shoes. Tenant #2 received no injuries from the incident.

On 11/26/24 at 2:23 pm, Staff A stated she worked when Tenant #2 eloped from the Program on 7/15/24. Staff A stated around dinner time, the electricity went out due to a thunderstorm. On 7/15/24, the tenants were all sitting in the dining room area. Staff A and Staff B assisted Tenant #6 to his apartment to use the restroom. Tenant #6's apartment door was adjacent to the dining area. Staff A stated Tenant #2 was sitting at the table when they left. While in Tenant #6's apartment, the back-up alarm sounded on the unit door. Staff A looked out into the dining area but saw nothing and assumed someone entered the unit. Staff A stated she continued helping Tenant #6. When Staff A and Staff B brought Tenant #6 back out to the dining area they noticed Tenant #2 was not in her seat. Both she and Staff B began to search the unit. Within a short time, a nurse from the nursing home side of the building brought Tenant #2 back into the unit. The nurse discovered Tenant #2 approximately 20 feet away from the outside door of the Program. Tenant #2 was missing 10 minutes or less. Staff A stated it was her belief the door lock did not work only during the brief period between the electricity going out and the generator coming on. It was only after

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A 150	Continued From page 2	A 150		

this incident that she learned the doors stayed unlocked during a power outage and the generator did not cover the locks, only the lights.

On 12/3/24 at 8:35 am, Staff B stated she worked when Tenant #2 eloped from the Program on 7/15/24. Staff B stated at around dinner time, the electricity went out due to a thunderstorm. She assisted Staff A to take Tenant #6 to the restroom at approximately 5:30 pm. Tenant #2 was sitting in the dining room when they entered Tenant #6's apartment. Staff B stated they were only in Tenant #6's apartment for a few minutes. Tenant #2 was not in the dining room when they came out. They began to search immediately but a nurse brought Tenant #2 back from outside.

On 11/26/24, a review of historical temperatures on Wunderground.com revealed at 5:54 pm on 7/15/24 it was 73 degrees, fair, with 3 mph winds.

When interviewed on 12/2/24 at 2:20 pm, the Maintenance Director stated the Program door unlocked anytime the electricity went out. The locks were not covered by the generator. The Maintenance Director stated the main alarm also did not work but the back-up alarm, which did not run on electricity, would sound.

On 12/3/24 at 11:20 am, the Director stated Staff A should have gone to the actual door and checked when the back-up alarm sounded instead of just looking out Tenant #6's apartment door. The Director stated both staff who worked were disciplined and all staff were retrained on policies.

On 12/3/24, the Program's policy titled Delayed Exit Code Alarm System was reviewed. The policy stated when a tenant attempted to open an

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A 150	Continued From page 3	A 150		

exit door, an alarm would sound and the door would not open for 15 seconds. Staff were to promptly go to the exit door if they heard the alarm sound in order to safely move the tenant away from the area. On 12/4/24, a review of personnel records revealed Staff A was trained on all policies on 2/8/21 and Staff B was trained on all policies on 5/11/22.

On 12/2/24 at 9:44 am, the surveyor entered the Program. When the surveyor entered, the door alarm sounded. No staff came to check the exit door to see who set off the alarm until 9:48 am. On 12/3/24 at 10:16 am, the surveyor entered the Program. The door alarm sounded upon entry. No staff arrived to check to see who set off the alarm system. The Director came back into the Program from the nursing home side of the building at 10:22 am and discovered the surveyor had arrived.

On 12/3/24 at 12:45 pm, the Director and the DON confirmed staff had not followed the Program's policy titled Delayed Exit Code Alarm System on 7/15/24 and had continued to not follow the policy during the onsite surveyor visit.

2). On 11/26/24 at 2:23 pm, Staff A stated she worked when Tenant #2 eloped from the Program on 7/15/24. Staff A stated the electricity went out shortly before dinner. After Tenant #2 eloped and was returned to the Program, staff kept a very close eye on her the rest of the night but had not documented hourly checks on all tenants in the Program after the electricity went out. Staff A could not recall how long the electricity was out.

On 12/3/24 at 8:35 am, Staff B stated she worked when Tenant #2 eloped from the Program on 7/15/24. Staff B stated at around dinner time, the

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A 150	Continued From page 4	A 150		

electricity went out due to a thunderstorm. After Tenant #2 eloped and was returned to the Program, staff kept a very close eye on all of the tenants the rest of the night but had not documented hourly checks on everyone. Staff B stated she was not sure how long the electricity was out, but that it went out right before dinner at 5:30 pm and was still off when she ended her shift at 8:00 pm.

On 12/3/24, a review of the Program's Electrical Outage policy was reviewed. The policy directed staff were to complete a door to door wellness check on all tenants at the time of the electrical outage and every hour thereafter. The checks would be documented on the Visual Check sheet.

On 12/3/24 at 11:20 am, the Director stated Staff A and Staff B were disciplined for not conducting/documenting hourly checks on all tenants in the Program.

On 12/3/24 at 12:45 pm, the Director and the DON confirmed staff failed to document the initial and hourly checks on all tenants during the power outage on 7/15/24.

3) a. On 12/2/24, a review of Tenant #3's record revealed a diagnosis of dementia. A review of Tenant #3's incident reports revealed the following unwitnessed falls:
- On 9/25/24 Tenant #3 was found sitting on her apartment floor with no apparent injuries upon nurse assessment. Tenant #3's physician was notified but no head injury protocol was completed.
- On 11/21/24 Tenant #3 was found sitting on the floor of her apartment with her back against her couch. Tenant #3 had no apparent injuries upon nurse assessment. Tenant #3's physician was not

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A 150	Continued From page 5 contacted and no head injury protocol was completed. b. On 12/2/24, a review of Tenant #4's record revealed a diagnosis of dementia. A review of Tenant #4's incident reports revealed an unwitnessed fall on 9/22/24. Per the incident report, staff heard Tenant #4 yell for help. She was found lying on her left hip outside of another tenant's apartment. Tenant #4 had no apparent injuries. Her physician was notified but no head injury protocol was completed. c. On 12/2/24 a review of Tenant #5's record revealed a diagnosis of dementia. A review of Tenant #5's incident reports revealed an unwitnessed fall on 9/8/24. Tenant #5 was discovered sitting on the floor of her apartment. Tenant #5 had no apparent injuries. Tenant #5's physician was notified but no head injury protocol was completed. d. On 12/2/24 a review of the Program's policy titled Fall with a Possible Head Injury was reviewed. The policy indicated all unwitnessed falls were to be treated as a potential head injury. The Program procedures per the policy for an unwitnessed fall with a potential of a head injury was for the nurse to implement the head injury protocol for assessment and evaluation for neurological changes and to notify the tenant's physician or physician on call of any neurological changes. The protocol included a neurological assessment immediately after the fall, every 15 minutes x4; every 30 minutes x2; every 1 hour x4; and every shift x24 hours, using the neurological flow sheet. e. On 12/3/24 at 12:45 pm, the Director and DON confirmed the policy for Falls with a Possible	A 150		

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A 150	Continued From page 6 Head Injury was not followed for the unwitnessed falls sustained by Tenant #3, Tenant #4 and Tenant #5.	A 150		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 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 address all individualized service needs within the service plan for 1 of 5 tenants reviewed (Tenant #3). Findings include: 1. On 12/2/24, a review of Tenant #3's record revealed a nurse review dated 9/11/24. The nurse review identified Tenant #3 used a front-wheeled walker and a wheelchair for longer distances. The nurse review noted staff needed to remind Tenant #3 to use the walker as she often failed to use it. It further indicated Tenant #3 required reminders to come to activities. On 12/2/24, a review of Tenant #3's incident reports revealed she had falls on the following dates: 9/5/24, 9/25/24, 10/6/24, 11/17/24 and 11/21/24.	A 350		

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A 350	Continued From page 7 Tenant #3's service plan dated 11/24/24 failed to include information regarding her devices for ambulation, staff reminders to use her devices, staff reminders to come to activities, and her history of falls and staff interventions. 2. On 12/3/24 at 12:45 pm, the Director of Nursing and the Director confirmed the service plan for Tenant #3 failed to address all of her individualized service needs.	A 350		

Maple Crest
MANOR THE MAPLES & MAPLE MEMORY LANE

100 Bolger Drive

Fayette, IA 52142

563-425-3336

Atten: Deb Dixon

Plan of correction:

Tag A150:

The Program shall follow the policies and procedures established by the program.

1. We will review our policies and procedure for delayed exit code alarm system, electrical outage and falls with possible head injury with staff.
2. We will be auditing on each shift monthly to ensure that policies and procedures are being followed.
3. This will be implemented by 3/11/25

Tag A350:

Service Plans

1. Service plans have been reviewed and will include all individual needs.
2. Going forward all service plans will be reviewed by nurse and administrator to ensure all individual needs are listed.
3. All service plans will be reviewed annually or at change of condition
4. This will be implemented by 3/11/25

Angelique Lueder, Director

Maple Memory Lane

100 Bolger Dr.

Fayette, IA 52142