

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0350</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/28/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MAPLE MEMORY LANE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 BOLGER DRIVE</b> <b>FAYETTE, IA 52142</b>
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(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	<p>Initial Comments</p> <p>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.</p> <p>Number of tenants without cognitive impairment: 1 Number of tenants with cognitive impairment: 11 Total census: 12</p> <p>The following regulatory insufficiencies were cited during the investigation of Incident #116772-I. No regulatory insufficiencies were cited during the investigation of Complaint #110207-C.</p>	A 000		
A 150	<p>481-67.2(3) Program Policies and Procedures</p> <p>67.2(3) The program shall follow the policies and procedures established by the program.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to follow established policy on incident reports for 1 of 3 tenants reviewed (Tenant #1). Findings include:</p> <p>1. On 11/27/23, a review of Tenant #1's record revealed an admission date of 9/14/23. A review of nurse's notes revealed a note dated 11/8/23 written by the Licensed Practical Nurse (LPN). The LPN wrote she was notified that Tenant #1 eloped from the Program at around 5:10 am. At 5:25 am, Tenant #1 was discovered outside in the fenced-in courtyard standing behind a bush. The tenant was wearing a flannel pajama top and flannel pajama pants with socks and slippers.</p>	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	<p>Continued From page 1</p> <p>According to wunderground.com, the temperature outside at the time of the elopement was 44 degrees Fahrenheit. Tenant #1 was assessed at the emergency room after the incident.</p> <p>2. On 11/27/23, a review of the Program's policy titled Incidents - Accidents revealed if an occurrence or event lead to unintentional consequences or an unfortunate happening to a tenant, an Incident - Accident Report must be completed.</p> <p>3. On 11/27/23, a review of Program Incident reports for the past 3 months revealed no Incident - Accident Report form was completed for Tenant #1's elopement on 11/8/23.</p> <p>4. On 11/27/23 at 1:30 pm, the Registered Nurse (RN) confirmed no incident report was completed on the elopement.</p>	A 150		
A 395	<p>481-69.26(4)a Service Plans</p> <p>69.26(4) The service plan shall be individualized and shall indicate, at a minimum:</p> <p>a. The tenant's identified needs and preferences for assistance</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the Program failed to address all assessed needs within the service plan for 1 of 3 tenants reviewed (Tenant #1). Findings include:</p> <p>1. On 11/27/23, a review of Tenant #1's record revealed an admission date of 9/14/23. Tenant #1</p>	A 395		

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A 395	<p>Continued From page 2</p> <p>had a diagnosis of dementia. A review of nurse's notes revealed a note dated 11/8/23 written by the Licensed Practical Nurse (LPN). The LPN wrote she was notified that Tenant #1 eloped from the Program at around 5:10 am. At 5:25 am, Tenant #1 was discovered outside in the fenced-in courtyard standing behind a bush. The tenant was wearing a flannel pajama top and flannel pajama pants with socks and slippers. According to wunderground.com, the temperature outside at the time of the elopement was 44 degrees Fahrenheit. Tenant #1 was assessed at the emergency room after the incident. Tenant #1's record revealed a service plan dated 10/13/23 that revealed no concerns with Tenant #1 wandering in the Program or having elopement issues.</p> <p>2. On 11/27/23 at 11:57 am, the LPN stated Tenant #1 was returned to the Program several hours later on 11/8/23 after her emergency room assessment with no new orders.</p> <p>3. On 11/27/23 at 12:17 pm, Staff A stated she had last observed Tenant #1 in her room laying on her bed at the 4:30 am safety check. Staff A stated Tenant #1's apartment door was open and her light was on at the 5:00 am safety check. It was common for Tenant #1 to be up out of bed during the overnight hours and wander or sit in a chair in the common areas. Staff A stated she had observed Tenant #1 wander into other tenant apartments before or test door handles to see if she could enter.</p> <p>4. On 11/27/23 at 12:44 pm, Staff B stated Tenant #1 frequently wandered in the unit. Staff B had observed Tenant #1 go into other tenant apartments and attempt to open doors before. Staff B stated Tenant #1 could be fast.</p>	A 395		

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A 395	Continued From page 3  5. On 11/27/23 at 1:30 pm, the Registered Nurse (RN) confirmed the service plan did not contain information regarding Tenant #1's wandering behaviors prior to the incident on 11/8/23 nor was it updated after the incident to include information on elopements.	A 395		

## Maple Crest Campus- Plan of Correction

Incident #116772-I

Program Policy and Procedures

A150

As of 11/29/23 for all future elopements the RN will fill out an incident form. The D.O.N. will follow up if there falls or incidents that the proper paper work is completed.

A395

As of 11/29/24 registered nurse went through all care plans of tenants who tend to wonder or exit seek and added note to service plan so staff is aware of the behavior.