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
	S0360	A. BUILDING: _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT FOREVERGREEN ALP/I	1275 W FOREVERGREEN ROAD NORTH LIBERTY, IA 52317

(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: 2 Number of tenants with cognitive impairment: 19 Total census: 21 The following regulatory insufficiencies were cited during the investigation of Incident #121790-I and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000	See Attached POC 9/30/24	
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 the Life Safety policy on staff response to memory care door alarms for 1 of 1 tenants who eloped over the prior month (Tenant #1). Findings follow: Record review of an incident investigation dated 6/24/24 revealed Tenant #1 woke up around 4:45 AM asking to walk across the street. Staff A reported he could not go out any of the doors as they were emergency exits. Staff A assisted Tenant #1 to sit down in the commons area and left to check on other tenants. Staff A heard a door alarm sound and came back to the dining	A 150		

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A 150	Continued From page 1	A 150		

room area. Staff B shut off the alarm and assisted Tenant #1 back to his room. Staff A continued her checks on other tenants when Tenant #1 came out of his room and began wandering the halls. Staff A continued to check other tenants when she heard the door alarm go off again. Staff A returned to the commons area and noted the garden door alarm was going off. Staff A went to the garden door, turned off the alarm, looked outside but did not see Tenant #1. She returned to the unit, looked down the hall and then walked back to the medication cart. Staff A did not search for Tenant #1 or ensure the location of all tenants. Staff A heard knocking on the garden door and saw Tenant #1 trying to get back in from the courtyard. Staff A let Tenant #1 in the building and provided 1:1 supervision until the next shift arrived. Staff A notified the nurse on-call at 6:16 AM of the incident.

The program developed a Resident Assessment on 12/5/23 for Tenant #1. Tenant #1 scored a 5 on the Global Deterioration Scale indicating moderately severe cognitive decline. The assessment identified Tenant #1 may exit-seek by following others when they leave the unit. Staff were to provide Tenant #1 with verbal and physical redirection as needed, offer a diversional activity, provide 1:1 supervision, offer a snack or turn the television onto a sports channel. Tenant #1 received safety checks every two hours to ensure his safety. He required redirection and supervision due to his elopement and wandering risk. Tenant #1 was impendent with ambulation and transfers.

On 7/2/24 at 8:00 AM, Staff A reported when Tenant #1 woke up on 6/24/24, he was walking to all of the doors on the memory care unit and shaking them. He was pretty upset when she

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A 150	Continued From page 2	A 150		

attempted to redirect him. Staff B assisted Tenant #1 the first time the door alarm sounded. The second time Staff A heard the door alarm, she responded. Staff A looked outside the garden door but it was dark outside and she did not see any tenants. She thought Tenant #1 must have pushed the door to cause the alarm but she believed he then went back inside. Staff A looked in the hallway, but it was also dark and she did not see Tenant #1. About 1-2 minutes later, Tenant #1 approached the garden door wanting to get back in. Tenant #1 was upset because he could not get off the unit. Staff A said she was trained to stay with tenants who were exit-seeking.

On 7/2/24 at 8:20 AM, Staff B recalled Tenant #1 was awake much of the night. She would escort Tenant #1 to his room, he would get up and go to the living room and try to open the doors. Staff B responded to the door alarm once when Tenant #1 opened the door. After this occurred, Staff B took Tenant #1 to his room. She then went to do her last round of checking on other tenants for the day. Staff B was in another tenant's apartment when the second alarm went off. She assumed he was still in his apartment.

The Life Safety policy on staff response when a door alarm was sounding indicated staff should IMMEDIATELY respond to the door alarming. Attempt to determine what set off the alarm. OPEN THE DOOR AND LOOK TO SEE IF A TENANT IS IN SIGHT. WALK OUTSIDE AND QUICKLY SCAN THE GROUNDS. ALWAYS ASSUME IT IS A TENANT WHO ACTIVATED THE ALARM (capitals per policy).

On 7/2/24 at 8:35 AM the Director of Health and Wellness reported a video of the incident was no

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A 150	Continued From page 3 longer available, however she took notes about the incident. The alarm sounded at 5:07 AM. Staff A arrived at the door at 5:08 AM, shut off the alarm and looked outside. At 5:09 AM, Staff A turned away from the door and walked to the commons area, looking down the hallway. Staff A then returned to the medication cart, she did not look for Tenant #1 in the building. Staff A returned to the garden door at 5:10 AM and let Tenant #1 in after hearing him knock. The Director of Health and Wellness confirmed Staff A and Staff B did not follow the Life and Safety policy when she did not search for Tenant #1 after the alarm sounded.	A 150		
A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on interview and record review, staff failed to supervise 1 of 1 tenants reviewed who were admitted in the past four months according to the training they received (Tenant #1). Findings include: - Record review of observation notes for Tenant #1 revealed he had an increase in exit-seeking behaviors on 4/16/24. Tenant #1 was noticed to almost stumble and fall when attempting to jog to	A 361		

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A 361	Continued From page 4	A 361		

an exit door which was opened by a visitor or employee. Staff were instructed to keep one member in the day room at all times to monitor exit doors and one staff member in the hallway to monitor the back exit door.

- A 90-day nurse review was completed for Tenant #1 on 5/13/24 noting he continued to have issues related to cognitive status, requiring 1:1 supervision from staff at times. Due to his intermittent 1:1 needs and repeated behaviors, the program recommended a private duty caregiver or family provide assistance at times.

- Staff documented providing 1:1 supervision of Tenant #1 during episodes of wandering or exit-seeking on the following dates: 4/22/24, 5/5/24, 5/8/24, 6/12/24 and 6/13/24.

An incident investigation dated 6/24/24 revealed Tenant #1 woke up around 4:45 AM asking to walk across the street. Staff A reported he could not go out any of the doors as they were emergency exits. Staff A assisted Tenant #1 to sit down in the commons area and left to check on other tenants. Staff A heard a door alarm sound and came back to the dining room area. Staff B shut off the alarm and assisted Tenant #1 back to his room. Staff A continued her checks on other tenants when Tenant #1 came out of his room and began wandering the halls. Staff A continued to check other tenants when she heard the door alarm go off again. Staff A returned to the commons area and noted the garden door alarm was going off. Staff A went to the garden door, turned off the alarm, looked outside but did not see Tenant #1. She returned to the unit, looked down the hall and then walked back to the medication cart. Staff A did not search for Tenant #1 or ensure the location of all tenants. Staff A

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A 361	Continued From page 5	A 361		

heard knocking on the garden door and saw Tenant #1 trying to get back in from the courtyard. Staff A let Tenant #1 in the building and provided 1:1 supervision until the next shift arrived. Staff A notified the nurse on-call at 6:16 AM of the incident.

The program developed a Resident Assessment on 12/5/23 for Tenant #1. The assessment identified Tenant #1 may exit-seek by following others when they leave the unit. Staff were to provide Tenant #1 with verbal and physical redirection as needed, offer a diversional activity, provide 1:1 supervision, offer a snack or turn the television onto a sports channel.

On 7/2/24 at 8:00 AM, Staff A reported when Tenant #1 woke up on 6/24/24, he was walking to all of the doors on the memory care unit and shaking them. He was pretty upset when she attempted to redirect him. Staff B assisted Tenant #1 the first time the door alarm sounded. The second time Staff A heard the door alarm, she responded. Staff A looked outside the garden door but it was dark outside and she did not see any tenants. She thought Tenant #1 must have pushed the door to cause the alarm but she believed he then went back inside. Staff A looked in the hallway, but it was also dark and she did not see Tenant #1. About 1-2 minutes later, Tenant #1 approached the garden door wanting to get back in. Tenant #1 was upset because he could not get off the unit. Staff A said she was trained to stay with tenants who were exit-seeking.

On 7/2/24 at 8:20 AM, Staff B recalled Tenant #1 was awake much of the night. She would escort Tenant #1 to his room, he would get up and go to the living room and try to open the doors. Staff B

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A 361	Continued From page 6 responded to the door alarm once when Tenant #1 opened the door. After this occurred, Staff B took Tenant #1 to his room. She then went to do her last round of checking on other tenants for the day. Staff B was in another tenant's apartment when the second alarm went off. She assumed he was still in his apartment. On 7/2/24 at 8:35 AM the Director of Health and Wellness reported she trained staff to provide tenants with 1:1 supervision when they displayed exit-seeking behaviors. She confirmed Staff A and Staff B did not supervise Tenant #1 in accordance with their training on 6/24/24.	A 361		
A 355	481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure 2 of 3 tenants reviewed signed the occupancy agreement prior to taking occupancy of their apartments (Tenant #1 and Tenant #2). Findings follow: Record review on 7/1/24 revealed Tenant #1	A 355		

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A 355	Continued From page 7 moved to the program on 3/24/23. The occupancy agreement was not signed until 4/1/23, after the date of admission. Tenant #2 moved to the program on 8/7/23. Her occupancy agreement was signed on 8/8/23, after she moved to her apartment. On 7/2/24 at 12:09 PM the Executive Director confirmed these findings.	A 355		
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 ensure the service plan addressed the identified needs of 1 of 1 tenants admitted within the past four months (Tenant #1). Findings follow: - Record review of observation notes for Tenant #1 revealed on 4/1/24, the Registered Nurse (RN) received a nurse communication form from 3/30/24 at 10:10 PM indicating the tenant was found sitting on another tenant's bed when that person was asleep. Tenant #1 seemed confused. Tenant #1 started on a higher dose of seroquel on 3/27/24 for increased agitation and confusion. Tenant #1 was noted to have increased wandering throughout the memory care unit.	A 395		

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A 395	Continued From page 8 - Tenant #1 had increased exit-seeking behaviors on 4/16/24. Tenant #1 was noticed to almost stumble and fall when attempting to jog to an exit door which was opened by a visitor or employee. Staff were instructed to keep one member in the day room at all times to monitor exit doors and one staff member in the hallway to monitor the back exit door. - On 4/19/24, Tenant #1 was very restless and unable to be redirected or distracted and it was somewhat disruptive to the memory care milieu. Tenant #1's doctor was contacted about the increased behaviors and restlessness. - On 4/21/24 in the late evening, Tenant #1 was very restless and wandering around the hallway of the unit opening the doors to other tenants' apartments and turning on the light switches. Staff locked other tenants' door to prevent Tenant #1 from entering the apartments and disturbing them. If Tenant #1 tried a peer's door and it was locked, he would mule-kick the door. Tenant #1's doctor was again contacted and he was prescribed a new medication, trazodone. - Program staff contacted Tenant #1's doctor on 5/1/24 to report he continued to wander the unit, knocking and opening other tenants' doors and turning on lights which was disturbing to them. The behaviors seemed less aggressive but continued. When Tenant #1 had elevated behaviors, he required 1:1 monitoring. - On 5/5/24, Tenant #1 was wandering the unit at 9:30 PM knocking on doors. He required 1:1 monitoring but even this did not allow staff to redirect him from other's apartments. Tenant #1 was sent to the emergency room (ER) for	A 395		

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treatment but the ER staff reported it was not a medical issue. The Executive Director contacted the Ombudsman's office on 5/6/24 to discuss Tenant #1's on-going wandering into other tenant's apartments and disrupting the environment. All interventions were noted to be exhausted.

- Tenant #1's actions continued on 5/8/24. The program discussed hiring a private caregiver with Tenant #1's family. The Executive Director spoke with Tenant #1's family about exploring care options at a long-term care facility on 5/13/24.

- Tenant #1 was noted to enter other tenant's apartments and set off door alarms on 5/15/24.

- Tenant #1's family was given an informal 30-day notice on 5/17/24.

The program developed a Service Plan on 12/5/23 for Tenant #1. The service plan identified Tenant #1 may exit-seek by following others when they left the unit. Staff were to provide Tenant #1 with verbal and physical redirection as needed, offer a diversional activity, provide 1:1 supervision, offer a snack or turn the television onto a sports channel. He required redirection and supervision due to his elopement and wandering risk. Tenant #1's service plan was not updated following his increase in wandering into other's apartments. The service plan did not add interventions when Tenant #1 began entering others' apartments, turning on their lights and disrupting their comfort.

On 7/2/24 at 8:35 AM the Director of Health and Wellness reported Tenant #1's service plan was not updated to address his increased wandering.

ok

Keystone Place at Forevergreen
Plan of Correction
September 16, 2024

A 150-- Program Policies and Procedures: 481-67.2(3)

Findings: The program failed to follow the Life Safety policy on staff response to memory care door alarms.

Plan of Correction:

1. All health and wellness staff were trained on the Keystone Place at Forevergreen Life-Safety Memory Care dated February 27, 2023 prior to September 9, 2024. The community updated its Life-Safety Memory Policy and Procedure dated September 14, 2024. All health and wellness staff will be retrained on the Keystone Place at Forevergreen Life Safety-Memory Care Policy-Procedure dated September 14, 2024 by September 30, 2024. All health and wellness staff will receive annual in-service training on the Life-Safety Memory Care Policy and Procedure. The new policy provides clarification on measures to address conducting a lit search of the memory care courtyard and clarifies that although the courtyard is secured a resident should not be left in the courtyard unsupervised. All new memory care staff will be required to sign acknowledgement of initial training on the Life-Safety Memory Care Policy and documentation will be placed in the staff member's personnel file. The community has created a new position, RN Memory Care Supervisor with responsibility for the ongoing wellbeing of memory care residents.
2. The Director of Health and Wellness or a nurse designee will review all incident reports on no less frequently than a weekly basis to ensure there are no incidences of staff failure to comply with the Keystone Place at Forevergreen Life Safety-Memory Care Policy-Procedure. Any incidents regarding memory care residents will be reviewed by the Director of Health and Wellness and the RN Memory Care Supervisor and additional staff training or other corrective measures will be implemented promptly if warranted by an incident and staff response.
3. In the event of any repeat occurrence upon review of incident reports, the Director of Health and Wellness and RN Memory Care Supervisor retrain staff involved in a one on one setting and conduct skills reviews with the particular staff member.
4. Corrections will be completed no later than September 30, 2024.

A 361-- Staffing 481-67.9(4)f

Findings: Staff failed to supervise 1 of 1 tenant reviewed who were admitted in the past four months according to the training they received.

Plan of Correction:

1. All health and wellness staff were trained on the Keystone Place at Forevergreen Life-Safety Memory Care dated February 27, 2023 prior to September 9, 2024. The community updated its Life-Safety Memory Policy and Procedure dated September 14, 2024. All health and wellness staff will be retrained on the Keystone Place at Forevergreen Life Safety-Memory Care

Policy-Procedure dated September 14, 2024 by September 30, 2024. All health and wellness staff will receive annual in-service training on the Life-Safety Memory Care Policy and Procedure. The new policy provides clarification on staff supervision of memory care tenants and requires that memory care tenants not be unattended in the memory care courtyard during non-daylight hours. All new memory care staff will be required to sign acknowledgement of initial training on the Life-Safety Memory Care Policy and documentation will be placed in the staff member's personnel file. The community has created two new positions, RN Memory Care Supervisor and Memory Care Engagement Coordinator with responsibility for the ongoing wellbeing of memory care residents. The Memory Care Engagement Coordinator will assist in documentation of resident incidents and share in the responsibility for providing and maintaining an environment that is reasonably conducive to the safety and physical and emotional well-being of residents. All care staff will be retrained on reviewing service plans and following care plans while on duty by September 30th, 2024.

2. The Director of Health and Wellness or a nurse designee and the RN Memory Care Supervisor will review all delegations on a quarterly basis to ensure compliance with services being provided.
3. In the event it is identified that a staff member is not carrying out delegations, the Director of Health and Wellness or RN Memory Care Supervisor will retrain staff involved in a one on one setting and conduct skills reviews with the particular staff member.
4. Corrections will be completed no later than September 30, 2024.

A 355—Service Plans 481-69.26(2)

Findings: The program failed to ensure 2 of 3 tenants reviewed signed the occupancy agreement prior to taking occupancy of their apartments.

Plan of Correction:

1. The Community will not be permitted to accept any resident for occupancy prior to completion of the Service Plan and residence and services agreement, which must be signed by the resident or the resident's responsible party. In the event a resident's responsible party is not available in person, the Community will accept an electronic signature by a resident's responsible party. In the event a resident desires to secure an apartment prior to the move in date, the Schedule of Fees to the residence and services agreement must include a notation of the financial responsibility date and the move-in date.
2. The Executive Director and the Director of Operations will ensure no move-in is scheduled without prior physical review of completed and signed service plan and residence and services agreement.
3. The Director of Operations will complete a quarterly review of all new resident agreements to ensure all service plans and residence and services agreements predate or are dated on the date of a resident's move in.
4. Corrections were completed on September 6 , 2024.

A 395—Service Plans 481-69.26(4)a

Findings: The program failed to ensure the service plan addressed the identified needs of 1 of 1 tenants admitted within the past four months.

Plan of Correction:

1. The Community updated its Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure dated September 14, 2024. All health and wellness nurses will be retrained on the Keystone Place at Forevergreen Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure dated September 14, 2024 by September 30, 2024. All nursing staff will receive annual in-service training on Resident Service Plans: Evaluation, Implementation and Revisions Policy and Procedure. The new policy provides clarification on inclusion of a resident's history of exit seeking, elopement attempts, frequent falls, inappropriate behavior any matters regarding the resident which are extraordinary and clarifies that anything that requires staff assistance needs to be noted in the Service Plan, even if additional services are needed on a temporary basis. The Director of Health and Wellness will review service plans, nurse reviews, and change of condition requirements with all current nursing staff by September 30, 2024.
2. The Director of Health and Wellness or a nurse designee will conduct reviews of a random sample of service plans on a quarterly basis to ensure compliance plans appropriate document services being provided.
3. Resident service plans will be reviewed at all 90 day assessments to ensure the service plan meets the tenant's needs. All staff nurses will collaborate with Director of Health and Wellness regarding staff to nurse communications to determine if a nurse review or change of condition for a particular resident may be warranted.
4. Corrections will be completed no later than September 30, 2024.