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
	S0163	A. BUILDING: _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY GARDENS	15 SILVERCREST PLACE IOWA CITY, IA 52240

(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	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 26 Total population of Program at time of on-site: 27 Total census of Assisted Living Program: 27 The following regulatory insufficiencies were cited during the investigation of Incident # 66179-I:	A 000	See attached POC 7/1/17	
A 013	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 interviews and record reviews, the program failed to ensure one tenant received the care and services appropriate to her assessed needs (Tenant #1). Findings include: Tenant #1 was admitted on 6/20/15 and had a diagnosis of agitation, dementia, heart murmur, a history of falls, and constipation. Tenant #1's most recent health, functional, and cognitive evaluations, dated 4/22/17, revealed the following: Tenant #1 had fall precautions, required	A 013		

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A 013	Continued From page 1 around the clock safety checks, required one person assist for vision assistance, required minor assistance for bathing/dressing/toileting and activities. Tenant #1 was oriented to person and required minor cueing for cognitive issues. Tenant #1's problem areas were identified as: memory, irritability, judgement, and wandering. Tenant #1 had a GDS score of 4. Tenant #1's service plan, dated 12/8/16, indicated the following information regarding his/her moods/behavior: "Resident has a history of agitation, wandering, and exit seeking behaviors." On 5/8/17 an environmental tour and interview with the Director provided the following information: On 2/9/17, six staff supervised 27 tenants. The program had two doors tenants could leave the program and premises from, the front main lobby door and the main back door. All other exits went to secured courtyards. The program was split into two living units, a west side and east side which had alarmed doors going into the lobby area. The main lobby door was also alarmed. When someone exited a door without pressing the code into the keypad, an audible alarm sounds and a paging system alerts all staff members working by pager. Both the audible alarm and the pager alerts would continue to sound until a staff member reset the audible alarm by pressing the keypad and the pager system to all pagers by clearing the pagers using the main lobby computer system. Tenant #1's record and an incident report, dated 2/9/17, revealed the following incident: On 2/9/17 at 6:21 PM, the program received a call from Staff G who worked at a neighboring building Legacy Ridge Independent Living (approximately 50 yards from the Legacy Gardens building), reporting Tenant #1 was at the	A 013		

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A 013	Continued From page 2 Ridge building with no staff and appeared disoriented. Program staff had not known Tenant #1 was missing and sent a staff member to the Ridge to escort Tenant #1 back to the program. It is unknown how Tenant #1 left the building. Tenant #1 could have walked out behind a staff member or family member undetected if the individuals leaving did not know Tenant #1 resided at the program. The program did have signs to remind all people entering or leaving to be sensitive to this issue. Computer log systems indicated a service door between units in the back of the building sounded at 5:57 p.m. A staff member accidentally set this alarm off. Computer alarm system logs also indicated someone set off the alarm on the west side unit's door to the lobby area at 6:02 p.m. The log system then showed a 2nd alarm sounded at the main lobby door also at 6:02 p.m. Someone turned off both audible alarms after they sounded by pushing the code on the door pads. No staff admitted to turning off the audible alarms or hearing these alarms from the west unit door into the lobby or the main lobby door at 6:02 p.m. No staff admitted receiving a page from the paging system at 6:02 p.m. Someone did clear the paging system alert on the computer system at 6:10 p.m. for the 5:57 p.m. alarm, the alarm from the west unit door at 6:02 p.m., and the main lobby door at 6:02 p.m. Staff C cleared the 5:57 p.m. pager alert at 6:10 p.m., but did not admit to clearing the other two. On 2/9/17 from 3:00 p.m. to 5:55 p.m., Tenant #1 actively wandered and showed signs of exit seeking. On 5/9/17 at 9:04 a.m., Staff D stated he/she was aware of Tenant #1's history of wandering and exit seeking behavior. On 2/9/17, Staff D observed Tenant #1 walking toward the Southwest exit shortly after 5:50 p.m. Tenant #1	A 013		

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A 013	Continued From page 3 was redirected away from the exit by Staff A. On 5/9/17 at 12:41 PM, Staff F stated he/she was aware of Tenant #1's history of wandering and exit seeking behavior. On 5/9/17 at 12:20 p.m., Staff A stated he/she was aware of Tenant #1's history of wandering and exit seeking behavior. Staff A stated on 2/9/17 at around 5:55 p.m. to 6:00 p.m., he/she escorted Tenant #1 from the east side of the building to the west side of the building. Immediately after, he/she observed Tenant #1 heading toward the northwest courtyard door and had to be redirected by Staff A. Staff A then left the west side of the building to go to the east side. On 5/9/17 at 1:45 PM, Staff B stated he/she was aware of Tenant #1's history of wandering and exit seeking behavior. Staff B stated on 2/9/17 at 4:36 a.m., he/she found Tenant #1 set off the alarms for both the west side and east side units. Staff B turned off the alarms. Immediately after this, Tenant #1 headed straight for the northeast courtyard exit and had to be redirected by Staff E. On 2/9/17 in a written statement made for the Director, Staff C stated he/she came in to work at 6:00 PM on the night of 2/9. Staff C stated he/she heard the 5:57 PM alarm which was a co-worker going through a service door. Staff C stated he/she went and cleared this alarm page. This clear occurred at 6:10 PM which was 13 minutes after the page began for that alarm and 8 minutes after the 6:02 PM alarms which were cleared at the same time, 6:10 PM. Staff C stated he/she had not seen Tenant #1 at all prior to his/her elopement. The program's Alarmed Door Policy and Procedure For Locked Memory Unit revealed the following process: "If a door alarms, staff is to	A 013		

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A 013	Continued From page 4 immediately perform a physical check of the area that is outside of the door that alarmed to ensure that no tenant/resident is outside of the building and then the staff are to perform a physical check of each tenant/resident in the facility to ensure tenant/resident safety and to ensure that no tenant/resident has exited through the alarmed door. If additional assistance is required in performing a physical check of all tenant/residents, staff should radio for additional staff and request assistance in accounting for all of the tenant/residents." No one conducted a physical check of all tenants at the time of the main lobby door alarm at 6:02 PM. On 2/9/17, Tenant #1 was able to leave the premises without staff supervision or knowledge. All staff who worked that night denied hearing the audible alarms at 6:02 PM even though it was turned off by someone. Staff all denied receiving a pager alert from the 6:02 PM alarms even though they were cleared by someone on the computer at 6:10 PM. On 5/10/17 at 3 PM, the Director confirmed the above findings.	A 013		
A 230	481-69.32(4) Life Safety 481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements. 69.32(4) A program serving a person(s) with cognitive disorder or dementia shall have: a. Written procedures regarding alarm systems, if an alarm system is in place. b. Written procedures regarding appropriate staff response when a tenant ' s service plan indicates a risk of elopement or when a tenant	A 230		

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A 230	Continued From page 5 exhibits wandering behavior. c. Written procedures regarding appropriate staff response if a tenant with cognitive disorder or dementia is missing. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the program failed to ensure the program's alarm policy covered all areas of the alarm system notification, which included turning off an audible alarm by pressing a code in a keypad, a pager system automatically alerting all staff on duty and the clearing of the pager system after the alarm is investigated. The facility also failed to ensure the system was in working order and all staff were formally trained on the policy. This potentially affected 27 of 27 tenants living at the Program. A review of Tenant #1's record and an incident report, dated 2/9/17, revealed at 6:21 PM, the program received a call from Staff G who worked at a neighboring building, Legacy Ridge Independent Living (approximately 50 yards from the Legacy Gardens building) reporting Tenant #1 was at the Ridge building with no staff and appeared disoriented. Program staff were unaware Tenant #1 was missing and sent a staff member to the Ridge to escort Tenant #1 back to the program. Although it is unknown how the tenant left the building, a very plausible explanation could have been that he/she left at around 6:02 PM when an alarm sounded from the west exit which was where he/she was at during that time period and then a second alarm sounded for the main lobby door leaving the building. No staff admitted to turning off the audible alarm from either alarm, though someone must have. No staff admitted to receiving a page	A 230		

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A 230	Continued From page 6 at 6:02 PM or clearing the pager system which was completed at 6:10 PM. On 5/8/17 an environmental tour and interview with the Director provided the following information: On 2/9/17, six staff supervised 27 tenants. The program had two doors tenants could leave the program and premises from, the front main lobby door and the main back door. All other exits go to secured courtyards. The program was split into two living units, a west side and east side which have alarmed doors going into the lobby area. The main lobby door was also alarmed. When someone exited a door without pressing the code into the keypad, an audible alarm sounded and a paging system alerted all staff members working by pager. Both the audible alarm and the pager alerts continued to sound until a staff member reset the audible alarm by pressing the keypad and the pager system to all pagers by clearing the pagers using the main lobby computer system. A review of the program's Alarmed Door Policy and Procedure for Locked Memory Unit revealed the following instructions: 1. As part of the security system in this locked memory unit, all of the doors leading to the outside are alarmed/coded doors. 2. The proper way to exit the building through the doors is to enter the correct code into the keypad located in close proximity to the door. This will unlock the door and allow you to proceed through it. When the door closes, after a short delay it will lock again. 3. If a door alarms, staff is to immediately perform a physical check of the area that is outside of the door that alarmed to ensure that no tenant/resident is outside of the building and then	A 230		

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A 230	Continued From page 7	A 230		

the staff are to perform a physical check of each tenant/resident in the facility to ensure tenant/resident safety and to ensure that no tenant/resident has exited through the alarmed door. If additional assistance is required in performing a physical check of all tenant/residents, staff should radio for additional staff and request assistance in accounting for all of the tenant/residents.

The program's Alarmed Door Policy and Procedure for Locked Memory Unit did not fully address the alarmed doors and lacked information regarding the pager system alerts and the clearing system for the paging system.

Interviews on 5/9/17 with staff present during the elopement on 2/9/17, revealed past concerns regarding the alarm systems.

On 5/9/17 at 9:04 AM, Staff D stated the pagers could be individualized and staff could set the pagers to different ringtones, put the pager on vibrate or even silence the pager. Staff D also indicated the pagers contained log systems showing when pagers alerted, but believed staff could likely go back through and delete records out of it.

On 5/9/17 at 12:20 PM, Staff A stated that there have been past problems with the front main lobby door. Staff A stated there have been times where staff have not received a page from this door or that the alarm just went off without someone going through. Staff A stated the door has had problems with shutting just right in the past. Staff A was certain this problem was fixed now. Staff A also stated that some of the pagers are definitely in worse condition than others. Staff A stated that he/she did not receive a 6:02 PM

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A 230	Continued From page 8 page on the night of 2/9/17 and believed he/she likely had one of the bad pagers that always don't work or maybe his/her pager's battery was getting low. On 5/9/17 at 1:45 PM, Staff B stated that some pagers were older and you could not read what they said on them due to water damage or faded lines going through the screens. On 5/10/17 at 3 PM, the Director confirmed the above findings.	A 230		

RK 6/19/17 CAC 6/19/17

In Response to
Final Complaint/Incident Investigation
Dated June 14th 2017

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 deficiencies. The plan of correction is prepared is prepared and/or executed solely because it is required by the provisions of state law.

Evaluation

Regulatory Insufficiency: Tenant rights. All tenants have the following rights: To receive care, treatment and services which are adequate and appropriate (IAC r. 481-67.3(2)).

1. Elements detailing how the program will correct each regulatory insufficiency.
    a. Retraining will be completed with staff on use of equipment and procedure for clearing of alarms
    b. Elopement drills to be conducted routinely and as needed to ensure that staff responding appropriately to alarm system
    c. Review of service plans by RN staff to ensure residents care is adequately documented and information available for staff to review.
2. What measures will be taken to ensure the problem does not recur.
    a. Staff meeting was conducted on June 8th 2017. Reviewed with employees equipment needing to be worn at all times, and how to use equipment. Also working to ensure that all current employees have been delegated on elopement procedure and door alarm policies.
    b. Elopement Drills to be completed quarterly and as needed to ensure staff responding appropriately to alarms, and that process are being followed appropriately. Drills to be conducted by management staff.
    c. Training added to new employee orientation to ensure understanding of elopement policy and procedure as well as how to work equipment.
    d. Reviewed with staff understanding of service plans, location of service plans and explained that the care being provided to each resident is documented in the
    e. service plan. Staff expected to understand each resident individual needs based on their service plan.
3. How the Program plans to monitor performance to ensure compliance.
    a. Staff will continue to be trained and educated on alarm response policies and missing person's policy. Training will be documented in employee files.
    b. Elopement drills will be reviewed on a regular basis by DON and Regional DON to ensure staff understands process and will review any in time training needed during drills.
    c. All documentation will be reviewed on a regular basis by DON, and Regional RN. Any inconsistencies noted or training needed will be addressed by DON and

reported back to the Executive Director, Regional RN to ensure follow through and adherence to established policies.

4. The date by which the regulatory insufficiency will be corrected.
    a. The regulatory insufficiency will begin to be implemented and or corrected by July 1st 2017.

Evaluation

Regulatory Insufficiency: Life safety-emergency policies and procedures and structural safety requirements. A program serving a person(s) with cognitive disorder or dementia shall have:

a. written procedures regarding alarm systems, if an alarm system is in place.

b. Written procedures regarding appropriate staff response when a tenant's service plan indicates a risk of elopement or when a tenant exhibits wandering behavior.

c. Written procedures regarding appropriate staff response if a tenant with a cognitive disorder or dementia is missing (IAC r. 481-69.32(4)(a-c)).

1. Elements detailing how the program will correct each regulatory insufficiency.
    a. Policy and Procedures will be reviewed to ensure all areas of alarm system notification are identified in the policy.
    b. Maintenance of the door alarms will be preformed now and as needed in the event of any issues/concerns.
    c. Review of staff training on elopement/door alarm responses will be completed and will be documented in new hire employees orientation and or delegations.
2. What measures will be taken to ensure the problem does not recur
    a. Door alarm system was checked on February 10th 2017 by Stanley Security. No issues noted. All systems are working appropriately.
    b. Door alarms are checked weekly by maintenance staff, to ensure that alarm is setting off to main system and pagers are alarming appropriately.
    c. Equipment checked monthly, pagers and communication devices to ensure equipment is working accurately.
3. How the Program plans to monitor performance to ensure compliance.
    a. Regional Director of Nursing along with DON will monitor that equipment is checked monthly to ensure it is working appropriately.
    b. Regional DON along with DON will monitor that staff are trained on elopement/door alarm responses, by completing random audits and checks with staff.
4. The date by which the regulatory insufficiency will be corrected.
    a. The regulatory insufficiency will begin to be implemented and or corrected by July 1st 2017.