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
	S0365	A. BUILDING: _____ B. WING _____	C 01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND MEADOWS MC	5300 GRAND MEADOW DRIVE ASBURY, IA 52002

(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: 12 Number of tenants with cognitive impairment: 16 Total census: 28 The following regulatory insufficiencies were cited during the investigation of Incident #118162-I and Complaint #118161-C.	A 000	See Attached POC 2/23/24	
A 160	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 interview and record review, the Program failed to provide adequate and appropriate services for 1 of 3 tenants reviewed (Tenant #1). Findings include: On 1/23/24, a review of Tenant #1's record revealed an admission date of 1/5/24. Tenant #1 was a 63 year old male with a diagnosis of frontotemporal dementia. Tenant #1's most recent cognitive evaluation showed a Global	A 160		

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

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A 160	Continued From page 1	A 160		

Deterioration Scale (GDS) score of 4 (moderate cognitive decline). Tenant #1's service plan dated 1/5/24 flagged elopement risk as a concern and indicated Tenant #1 could wander and was easily redirected. Tenant #1's incident report dated 1/13/24, indicated Tenant #1 eloped from the memory care unit, Eisleban House (E-House). The incident report revealed Tenant #1 asked the Dietary Manager to let him out of the locked door. The Dietary Manager used his employee badge, opened the door and let Tenant #1 leave the unit at approximately 4:20 p.m. The Dietary Manager reported he believed Tenant #1 was a visitor. The Dietary Manager delivered meals to the attached assisted living unit at approximately 4:40 p.m. and observed Tenant #1 sat comfortably on a couch. According to the report, Tenant #1 walked approximately 255 feet outside from the memory care exit door to the assisted living door and entered.

According to wunderground.com, on 1/13/24 at 3:53 p.m., the temperature was 4 degrees Fahrenheit with 23 mile per hour winds.

When interviewed on 1/25/24 at 1:27 p.m., the Dietary Manager stated he entered the memory care, E-House unit between 4:15 p.m. and 4:30 p.m. He stated he observed Tenant #1 standing by the doorway. The Dietary Manager explained the man (Tenant #1) was dressed in a coat and looked like he was waiting to be let out. The Dietary Manager stated he never met Tenant #1 before and believed the man he saw was a visitor. Tenant #1 asked the Dietary Manager to buzz him out. The Dietary Manager used his badge and opened the door for him. The Dietary Manager put the food into the warmers for the memory care unit and left. The Dietary Manager stated he then delivered food to the assisted

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A 160	Continued From page 2	A 160		

living unit, Dubuque House approximately 20 minutes later. The Dietary Manager stated he observed the same man (Tenant #1) sitting on the couch comfortably in the sitting area of the assisted living unit. The Dietary Manager stated it was later the Director of Assisted Living informed him of his mistake.

When interviewed on 1/25/24 at 3:19 p.m., Staff C stated on 1/13/24 Staff B trained her in the memory care, E-House. Staff C stated Tenant #1 was wandering and she was told to watch him during down times. Staff C recalled she distracted him from wandering on the day of his elopement. Staff C stated at one point between 4:00 p.m. and 4:30 p.m., Staff C assisted Staff B and Staff D, who also worked in the memory care E-House, with Tenant #2. Staff C stated she believed Tenant #1 must have left the memory care during that time.

When interviewed on 1/25/24 at 3:24 p.m., Staff B stated she worked in the memory care, E-House and trained Staff C on 1/13/24. Staff B stated Tenant #1's sister visited him and then his wife visited him. Staff B stated when Tenant #1's sister visited he said he wanted to go home. Staff B recalled Tenant #1 wore a coat that day. Staff B explained at approximately 4:00 p.m. she passed medications in another memory care location. Staff B returned to Tenant #1's unit, E-House and assisted Staff C and Staff D with Tenant #2. After the staff finished assisting Tenant #2, they served dinner. Staff B stated Staff A suddenly entered the memory care unit and told the memory care staff she had Tenant #1 in the hallway outside of the assisted living unit and needed assistance in redirecting him back to the memory care unit. Staff B went to the hallway outside of the assisted living and redirected Tenant #1 back to the

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A 160	Continued From page 3	A 160		

memory care unit, E-House. Staff B stated Tenant #1 was immediately assessed by the long-term care unit nurse on duty which revealed no injuries. Staff B stated Tenant #1 wore a coat and had no complaints of being cold.

When interviewed on 1/25/24 at 5:45 p.m., Staff D stated on 1/13/24 he worked in the memory care, E-House with Staff B and Staff C. Staff D stated Tenant #1's wife visited during the late afternoon and they ate together. When the wife left, she let staff know Tenant #1 was in his apartment and already ate. Staff D, Staff B and Staff C then assisted Tenant #2 who required several staff to assist. The staff then went to the dining room and served dinner. Staff D stated they didn't expect Tenant #1 at the meal since he just ate with his wife. Eventually, Staff A arrived to the memory care unit and stated she believed she had Tenant #1 in the hallway and he entered the assisted living through the outside exit door. Staff D stated they were very confused how he could have gotten there as no door alarms sounded.

When interviewed on 1/25/24 at 3:01 p.m., Staff A stated on 1/13/24 she worked in the assisted living unit, Dubuque House. Staff A stated somewhere between 4:00 p.m. and 4:30 p.m., she administered insulin to a tenant and was getting ready to serve dinner when a man (Tenant #1) rang the doorbell to enter the assisted living unit from outside. He stood in the temperature controlled breezeway and looked in through the glass door. Staff A released the door lock and told the man (Tenant #1) to come in using the intercom. Staff A stated she never saw Tenant #1 before and she believed he was a visitor. Tenant #1 carried a few things and asked where Diane was. Staff A told Tenant #1 there was no Diane in

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A 160	Continued From page 4	A 160		

the assisted living but she would check with the long-term care unit if he wanted to have a seat. Tenant #1 went over to the sitting area next to the dining room and waited. Staff A quickly finished serving dinner to tenants and called the long-term care unit. The staff in the long-term care unit stated they didn't have a Diane. Staff A stated she looked over and noted Tenant #1 was on his phone so she then served desserts. Staff A stated Tenant #1 sat in the sitting area and just waited. Staff A went over to speak to Tenant #1 after she was finished serving food. Tenant #1 stated to her: do you see all those people over there? (pointing to the tenants eating dinner), They look 80 years old, I am going to shoot them. Staff A stated she told Tenant #1 she was going to find someone to help him. She immediately went back to the nurse's station and called Staff E from the long-term care unit and requested assistance. When Staff A got off the phone, Tenant #1 walked out of the assisted living into the main hallway that connected all units. Once outside of the assisted living unit doors, the wanderguard alarm sounded. Staff A stated it was then she realized Tenant #1 lived in the memory care unit as he wore a wanderguard system. Staff E from the long-term care unit arrived and she stayed with Tenant #1 while Staff A retrieved Staff B from the memory care, E-House. Staff B and Staff E walked Tenant #1 back to the memory care unit. Staff E, a nurse from the long-term care unit assessed Tenant #1, which resulted in no injuries.

When interviewed on 1/29/24 at 9:48 a.m., the Director of Assisted Living stated after Tenant #1 was returned to the memory care unit, E-House, she looked around and asked staff what they saw. The Director of Assisted Living discovered the Dietary Manager opened the door for Tenant #1 leading into the parking lot because he

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A 160	Continued From page 5 believed Tenant #1 was a visitor. Tenant #1 was stood at the door holding a few items and wore a coat. Tenant #1 asked the Dietary Manager to be buzzed outside. The Dietary Manager had never seen Tenant #1 before. The Dietary Manager was a contracted staff at the time of the incident. The Dietary Manager was still responsible for entering and exiting all units safely using his badge to deliver food. The Director of Assisted Living stated the Dietary Manager swiped his badge at the exit door which allowed Tenant #1 to exit. The Director of Assisted Living indicated there was no alarm on that door. The Director of Assisted Living confirmed all doors of the memory care were alarmed except that door. On 1/29/24 at 3:00 p.m., the Director of Assisted Living, the Administrator, and the Director of Nursing - Skilled Side, confirmed the above findings.	A 160		
A 555	481-69.30(3)a Dementia Specific Education for Personnel 69.30(3) Dementia-specific continuing education a Except as otherwise provided in this subrule, all personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	A 555		

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A 555	Continued From page 6 Program failed to consistently ensure contracted employees completed at least two hours of dementia-specific training. This pertained to one contract staff (Dietary Manager) findings include: On 1/29/24, a review of the Dietary Manager's personnel file revealed an initial hire date at the Program on 9/14/21. The dietary department went under new contracted ownership as of November 2023. The Dietary Manager's new hire date with the new company was 11/19/23. According to the Dietary Manager during an interview on 1/25/24 at 1:27 p.m., he stated delivering food to the memory care unit was part of his job responsibilities. The Dietary Manager's personnel file failed to include documentation of two hours of dementia-specific training in the past year. When interviewed on 1/29/24 at 3:00 p.m., the Director of Assisted Living, Administrator, and Director of Nursing for the Skilled Unit, confirmed the above finding.	A 555		
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 interviews, the Program failed to ensure a working alarm on all exit doors of the dementia-specific unit. This affected 14 tenants residing in the memory care,	A 635		

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A 635	Continued From page 7 Eisleban House (E-House). Findings include: When interviewed on 1/29/24 at 9:48 a.m., the Director of Assisted Living stated the door to the memory care unit, E-House that exited into the parking lot was locked only and contained no alarm system. The Director of Assisted Living explained the locked door only opened when a staff badge swiped the key pad. The Director of Assisted Living stated all other doors of the unit were alarmed. On 1/29/24 at 10:58 a.m., the Director of Assisted Living opened the memory care unit, E-House door and held it open for the surveyor to ensure no alarm sounded. The door did not sound an alarm. When interviewed on 1/29/24 at 11:14 am, the Director of Maintenance stated he examined the exit door and the door did not have an alarm system on it. On 1/29/24 at 3:00 p.m., the Director of Assisted Living, Administrator, and Director of Nursing - Skilled Side confirmed the above findings.	A 635		

LUTHERMANOR
COMMUNITIES

Grand Meadows

ALPD S0365 Plan of Correction

Please accept this as Luther Manor Communities – Grand Meadows Assisted Living credible allegation of compliance. This plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.

State Surveyor, Stephanie Radabaugh: Survey, 1/24-1/30.

Incident #118162-I

481-67.3(2) Tenant Rights - To receive care, treatment and services which are adequate and appropriate.
This requirement was not met as evidenced by Staff member shall not allow tenants out of the ALPD (MC) program.

A Staff meeting was provided on January 19, 2024, the staff from the ALPD and ALP were re-educated on the standard of practice to maintain the safety of the ALPD tenants through monitoring of individuals requesting to leave the unit for the purposes of confirming residents are not exiting the Memory Care households without supervision. Contracted staff are provided education on monitoring of the individuals requesting to exit prior to reporting to the assigned unit. The Universal Worker is the designated associate to unlock and release the controlled access doors to allow anyone other than staff to leave the household.

A Tenant Photo List has been posted in the Staff Breakroom for staff to familiarize themselves with the Memory Care tenants.

A wander guard alarm was installed at the main entrance door that exits outside. Project completed February 13, 2024.

Completion Date: February 13, 2024

Incident #118161-C

481-69.30(3)a Dementia Specific Education for Personnel

All personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually.

Staff are assigned the required two-hour training course to be completed through CE Solutions on-line training.

The Assisted Living Director and/or designee will monitor progress on completion of assigned Dependent Adult training by the required End of Quarter due date. This will be monitored weekly for the next 3 months and then the QAPI Committee will determine the need for continued monitoring and reporting to the QAPI Committee.

The Assisted Living Director and/or designee will conduct random monitoring of the knowledge of the ALPD staff on managing the secure doors and the process for individuals prior to exiting. After three months, if no issues are noted, random audits will be conducted to ensure quality of care and standards of practice in the memory care households.

Completion Date: February 23, 2024