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
	S0369	A. BUILDING: _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENCREST AT BEAVERDALE	3410 BEAVERDALE AVENUE DES MOINES, IA 50310

(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. General Population Number of tenants without cognitive disorder: 41 Number of tenants with cognitive disorder: 3 Memory Care Unit (if applicable) Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 39 TOTAL Census of Assisted Living Program for People with Dementia : 83 There were no regulatory insufficiencies cited during the investigation into Complaint #103179-C. The following regulatory insufficiencies were cited during the investigation into Incident # 104977-I and the recertification visit conducted to determine compliance with certification for an Assisted Living Program for People with Dementia.	A 000	**See Attached** **POC 7/1/22**	
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 consistently ensure service plans included tenants' identified needs. This affected 3 of 9 tenants reviewed (Tenant #2, #3,	A 395		

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A 395	Continued From page 1 #4). Findings follow: 1) Record review on 6/13/22 revealed tenant #2 was diagnosed with dementia in other diseases classified elsewhere with behavioral disturbance. Tenant #2 had a service plan dated 3/25/22. Her service plan identified she had severe memory loss and repeatedly asked the same question. Tenant #2 saw her PCP (primary care provider) on 5/11/22. A note from this appointment identified staff reported the patient had continued behaviors and anxiety. The PCP increased Tenant #2's antidepressant medication and said she would monitor it closely. On 6/9/22 at 10:25 AM, Staff D recalled Tenant #2 backhanded her when she assisted the tenant with toileting on one occasion. On 6/13/22 at 3:35 PM, Staff E reported Tenant #2 was physically and verbally aggressive with all cares. Tenant #2 hit, bit, kicked, spit and yelled at others daily. Giving Tenant #2 her PRN (as needed) medication helped with these behaviors. On 6/15/22 at 12:00 PM, the Registered Nurse (RN) confirmed Tenant #2 was very loud. Tenant #2 shouted, "help me" repeatedly, even when she did not need help, which upset the other tenants. Tenant #2 flailed her arms in the shower, which the RN said would be considered hitting. The RN confirmed these issues were not addressed in Tenant #2's service plan. 2) Tenant #3's service plan, dated 4/25/22, documented he was diagnosed with chronic obstructive pulmonary disease, unspecified; hypotension, unspecified; blindness and low	A 395		

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A 395	Continued From page 2	A 395		

vision, glaucoma and gastro-esophageal reflux disease without esophagitis. Tenant #3"s service plan noted he was oriented and able to recall or retain information. He exhibited normal, functional mood and socialization patterns.

On 6/9/22 at 11:05 AM, Staff C reported Tenant #3 talked about his penis regularly when she provided cares to him. Staff C informed the Director of this.

On 6/15/22 at 4:30 PM, Staff F stated Tenant #3 had acted out sexually with her. Staff F told the former Health Care Coordinator about Tenant #3's actions, however his behavior continued. Tenant #3 touched his penis and made sexual comments around Staff F. If Tenant #3 acted in this manner three evenings in a row, Staff F would ask a male staff member to put Tenant #3 to bed.

Staff G, a male, reported on 6/15/22 at 4:40 PM, Tenant #3 had not acted out sexually with him. However, several of his female co-workers told him Tenant #3 had behaved in a sexual manner with them.

On 6/15/22 at 12:00 PM, the RN reported she had not experienced any sexual acting out personally from Tenant #3 but she heard about it in passing. The RN believed the Resident Assistants knew how to back out of Tenant #3's apartment when he engaged in these behaviors. She assumed the former Health Care Coordinator discussed these issues with Tenant #3.

On 6/15/22 at 5:15 PM, the Portfolio Leader confirmed the former Health Care Coordinator was aware of Tenant #3's sexual behaviors and

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they were not addressed in his service plan.

3) Tenant #4's service plan, dated 11/20/21, noted she was diagnosed with vascular dementia without behavioral disturbance, gastro-esophageal reflux disease without esophagitis, essential hypertension, anxiety disorder and major depressive disorder. Tenant #4 was on hospice. She had mild to moderate disorientation with severe memory loss. Her service plan noted she was independent with meals and eating and drinking. Staff were to encourage fluids throughout the day and remind Tenant #4 to go to meals.

Tenant #4 was also noted to be incontinent of bladder. Staff were to take her to the toilet two times each shift and ensure she was wearing an incontinence undergarment. Tenant #4 repeatedly came out of her room looking for the restroom then got lost and had to be assisted back to her room.

Tenant #4 had a Hospice IDG Comprehensive Assessment and Plan of Care dated 4/27/22. Tenant #4 was noted to only eat a few bites of her meals. She was starting to pocket her food and drink. Tenant #4 could not understand the mechanics of silverware at times which frustrated her as well. Tenant #4 would use her hands to eat or stop eating all together.

Record review revealed a Progress Note, dated 5/20/22, detailed a team meeting with Tenant #4's representative, the hospice nurse, Director, RN and Dietary Manager. The program reported their staff could provide hand over hand assistance to Tenant #4 with feeding and cut up her food. Dietary would work with staff on finding

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food Tenant #4 liked and could manage. The program reported Tenant #4 did not need a higher level of care and could stay at the program, which was what all parties wanted.

The Hospice IDG Comprehensive Assessment and Plan of Care dated 5/25/22 identified Tenant #4 continued to lose weight. She was having more trouble feeding herself, getting to the restroom and experienced increased agitation. Tenant #4 pulled the fire alarm trying to get out of the building and might need a higher level of care. According to the notes, the program reported they could meet Tenant #4's needs by helping her at meal times, offering her water for adequate hydration. The Home Health Aide would try and schedule her visits at breakfast and lunch to help assist with breakfast and lunch. Tenant #4's weight decreased from 116 pounds on 2/7/22 to 112.3 pounds on 5/9/22 to 107 pounds on 5/23/22.

On 6/15/22 at 12:50 PM, Staff H reported Tenant #4 was not receiving finger foods at meal times, although she saw a list in the kitchen showing staff Tenant #4 and other tenants were to receive finger foods.

On 6/15/22 at 2:20 PM, Staff I said Tenant #4 did not receive finger foods at meal times.

On 6/15/22 at 5:15 PM, the Portfolio Leader confirmed Tenant #4's service plan did not reflect her dietary or ambulatory needs.

The Portfolio Leader confirmed the tenants' service plans did not address their identified needs. The program RN was updating the tenants' service plans at the time of the recertification visit.

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A 530	481-69.29(4) Staffing 481-69.29(231C) Staffing. 69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans. A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to properly supervise tenants according to their service plans This pertained to 1 of 9 tenants reviewed (Tenant #1). Findings follow: Record review on 6/8/22 revealed Tenant #1 was hospitalized prior to his admission to the program after he was found driving on the wrong side of the road by police. Tenant #1 was hospitalized from 4/9/22 until his discharge to the program on 5/5/22. Tenant #1 was diagnosed in the hospital with a Neuro cognitive disorder, unspecified; Depression and Hypertension. The program conducted a pre-move-in service	A 530		

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A 530	Continued From page 6	A 530		

plan for Tenant #1 on 5/3/22. It was noted he had mild to moderate disorientation or difficulty recalling/retaining information. Tenant #1 preferred nighttime checks. He was on safety checks eight times per shift. Staff were to check Tenant #1's wanderguard placement and functioning every shift.

Record review on 6/8/22 revealed an Incident Report dated 5/28/22 at 11:47 PM noted the Registered Nurse (RN) received a phone call from the Urbandale Fire Department stating they had Tenant #1 with them and thought he might live at their building (the nurse reported the call from the fire department came at 12:47 AM on 5/29/22). The RN confirmed the tenant did live at the program. Tenant #1 returned to the program at 1:04 AM on 5/29/22. The paramedics applied a coban wrap to Tenant #1's left elbow for a scrape he acquired while away from the program. The Incident report identified predisposing factors were the tenant's confusion, impaired memory and his status as an active exit-seeker.

According to an Internal Investigation, Tenant #1 removed his wanderguard prior to exiting the building at 9:59 PM. Tenant #1's ex-wife left scissors in his apartment hours prior to the incident, which he may have used to remove his wanderguard. Tenant #1 was last seen wearing his wanderguard by Staff A at 8:20 PM. When Tenant #1 left the building, he was dressed in long pants, a short-sleeved shirt and shoes. Tenant #1's wanderguard was reapplied and he moved to the memory care area.

On 6/8/22 at 2:45 PM, Staff D reported she worked 6:45 AM - 3:00 PM on 5/28/22. She reported Tenant #1 displayed no wandering behavior. Staff D said Tenant #1 had his

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A 530	Continued From page 7 WanderGuard on when she left at 3:00 PM. Staff D said she did not know how to check the functioning of the wanderguard. Staff A provided a written statement indicating she last saw Tenant #1 at 8:20 PM. She verified Tenant #1 was wearing his wanderguard at that time. Staff A was given a written warning for falsifying documentation. She documented she provided a visual check for Tenant #1 at 11:00 PM but did not do so as he left the building at 9:59 PM. On 6/8/22 at 4:35 PM, Staff B worked 9:30 PM 5/27/22 - 7:00 AM on 5/28/22. Staff B last saw Tenant #1 at 9:30 PM. Staff B said she did not complete any safety checks on Tenant #1 until he returned to the program following his elopement. Staff B generally worked 3rd shift. She said Tenant #1 was up and walked past her once prior to his elopement. Staff B generally came into work at 10:45 PM and said Tenant #1 was usually in bed. Tenant #1 told Staff B he left the building because he was not receiving his medication. Staff B reviewed his medication with him to reassure the tenant he was receiving it as prescribed. The Director and Portfolio Leader confirmed staff did not provide visual checks according to Tenant #1's service plan leading to staff being unaware of his whereabouts for over three hours.	A 530		
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.	A 635		

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A 635	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to have an operating alarm system on the front door to the building. This affected 1 of 1 tenant identified as a result of 104977-I and potentially affected all tenants of the program. Findings follow: Record review on 6/8/22 revealed an Incident Report dated 5/28/22 at 12:47 AM noted the Registered Nurse (RN) received a phone call from the Urbandale Fire Department stating they had Tenant #1 with them and thought he might live at their building (the nurse reported the call from the fire department came at 12:47 AM on 5/29/22). The RN confirmed the tenant did live at the program. Tenant #1 returned to the program at 1:04 AM on 5/29/22. The paramedics applied a coban wrap to Tenant #1's left elbow for a scrape he acquired while away from the program. The Incident Report identified predisposing factors were the tenant's confusion, impaired memory and his status as an active exit-seeker. According to an Internal Investigation, Tenant #1 removed his wanderguard prior to exiting the building. Tenant #1's ex-wife left scissors in his apartment hours prior to the incident, which he may have used to remove his wanderguard. Tenant #1 was last seen wearing his wanderguard by Staff A at 2020. When Tenant #1 left the building, he was dressed in long pants, a short-sleeved shirt and shoes. Tenant #1's wanderguard was reapplied and he moved to the memory care area. Record review revealed Tenant #1's pre-move in service plan dated 5/3/22. According to his	A 635		

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service plan, Tenant #1 had mild to moderate disorientation or difficulty recalling and retaining information. He preferred night time checks. Tenant #1 was on safety checks eight times per shift. Tenant #1 wore his wanderguard for safety to prevent wondering out of the community while adjusting to his new surroundings. Staff were to check Tenant #1's wanderguard placement and functioning every shift.

A review of a video provided by the program revealed Tenant #1 exited the building at 9:59 PM on 5/28/22 via the front door.

Several interviews were conducted with the Director on 6/8/22 and 6/9/22. On 6/9/22 at 12:00 PM, the Director and Portfolio Leader reported the front door had a Stanley alarm system. The Director said he checked the alarm system on a monthly basis. On 5/1/22, the Director checked and noted the alarm system was functioning properly and notified staff on their iPads when individuals entered or exited the building. The alarm system on the front door quit working on 5/15/22, although the Director had no means of providing documentation of this. The Director installed an Arial alarm system in the afternoon of 5/29/22, which notified staff when someone entered/exited the building on the iPads. No one was monitored the front door between 1:04 AM - the afternoon of 5/29/22 to ensure other tenants did not elope from the building. The monitor verified the iPads received notifications of visitors coming in and out of doors, including the front door. The Stanley alarm system was repaired so it would notify the Director when it malfunctioned. The Director checked all of the other doors and gates in the building and reported they were functioning properly.

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A 635	Continued From page 10	A 635		

When interviewed on 6/8/22 at 4:35 PM, Staff B,, who worked 9:45 PM 5/28/22 - 7:00 5/29/22 reported they were not aware Tenant #1 exited through the front door prior to receiving a call from the RN notifying her he was returning to the building with emergency personnel. An alarm did not sound when he left the building. Staff B was directed to monitor Tenant #1 closely upon his return. Tenant #1 told Staff B he left the building because no one was giving him his medication (although she checked Tenant #1's medication and she showed him he was receiving his pills properly).

On 6/9/22 at 8:45 AM, Staff J reported she worked in the memory care area on 5/28/22 from 2:45 PM - 10:45 PM, then worked on the assisted living area from 10:45 PM - 6:45 AM. Staff J saw Tenant #1 prior to his elopement in the hallway by his apartment. She reported he was not engaging in exit-seeking behavior. Staff J was not assigned to Tenant #1's area the night of his elopement and did not hear an alarm when he left. Upon his return Tenant #1 said he fell when trying to get out of the rain. He had no other injuries.

On 6/9/22 at 10:50 AM, the RN reported she checked the active exit-seeker box on the incident form for Tenant #1 following his elopement, although he had not displayed these behaviors prior to the elopement. The RN re-applied Tenant #1's wanderguard around 7:30 AM on 5/29/22.

The weather overnight from 5/28/22 - 5/29/22 was overcast without rain. The temperature was 68 degrees. Sundown was at 8:39 PM. The program was located on Beaver Road, a two-lane road with a center turning lane with a speed limit

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A 635	Continued From page 11 of 30 MPH. The tenant was gone for 3 hours and 4 minutes. He was unable to report where he was during this period of time, but was found by the Urbandale police at 8134 Douglas Avenue in Urbandale (3 miles away). Douglas Avenue is a busy, four-lane thoroughfare. The police contacted the Urbandale Fire Department/paramedics to assess treatment for Tenant #1.	A 635		

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Tag # 530	**Regulation and Reg Number** 481-69.29(4) Staffing *69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans.* This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to properly supervise tenants according to their service plans This pertained to 1 of 9 tenants reviewed (Tenant #1).	Tag # 530	-Instant Inservice completed with all staff -Counseling completed with specific staff involved in this incident. -Director and/or designee will monitor documentation to assure timeliness of safety/visual checks weekly, monthly, and as determined by the Director. -Upon hire and annually, training with staff regarding Elopement policy, including visual checks, wander-guard checks, and door alarm system will be completed by the Director and/or designee	-Director, Health Care Coordinator and Registered Nurse, or designee will provide upon hire and on an ongoing basis education to staff on the policy and procedures related to Elopement policy, visual checks, door alarm system, and wander-guard checks.	Implementation Date: 6/20/2022 Completion Date: 07/1/2022 Responsible Party: Director, Assistant Director, Health Care Coordinator, or Designee
Tag # 395	**Regulation and Reg Number** 481-69.26 (4) Service Plan *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 consistently ensure service plans included tenants' identified needs. This affected 3 of 9 tenants reviewed (Tenant #2, #3, #4).	Tag # 395	-Tenant # 2's ISP has been updated to include that resident is physically and verbally aggressive at times, specific interventions for these behaviors have been added to the service plan -Tenant #3's ISP has been updated to include the sexual behaviors that he at times, making sexually inappropriate comments toward staff, specific interventions for these behaviors have been added to the ISP. -Tenant # 4's ISP has been updated to include her dietary needs, staff to provide hand over hand assistance as needed with feeding, finger foods for meals, and staff assist to cut up her food as needed. Resident's aggression was also added to the ISP with specific interventions for these behaviors added to the ISP.	-Health Care Coordinator and Registered Nurse will review and update the service plan for each tenant based on their evaluations conducted and the service plans shall be designed to meet the specific needs of the individual tenant.	Implementation Date: 6/20/2022 Completion Date: 07/01/2022 Responsible Party: Director, Health Care Coordinator, or Designee
Tag #	**Regulation and Reg Number**	Tag #	-Resident moved to the secured memory	Resident is in a secured locked area	Implementation

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 interview and record review, the program failed to have an operating alarm system on the front door to the building. This affected 1 of 1 tenant identified as a result of 104977-I and potentially affected all tenants of the program.	635	care area of the community. -Instant in-service completed with all staff regarding visual checks, documentation, door alarms, wander-guards, and safety checks.	of the community with supervision. Resident receives visual checks for safety. Maintenance Coordinator or Designee will complete weekly audit of all community exit doors to assure alarms are functioning.	Date: 06/06/2022 Completion Date: 06/06/2022 Responsible Party: Director/Maintenance Coordinator, or Designee

Sarah Rokey, Community Director

Date: September 5,2022

Edencrest at Beaverdale