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
	S0380	A. BUILDING: _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BEND RETIREMENT COMMUNITY ALP/I	813 TYLER STREET NE CASCADE, IA 52033

(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 disorder: 2 Number of tenants with cognitive disorder: 12 Total census: 14 An onsite infection control survey was completed and no regulatory insufficiencies were identified. The following regulatory insufficiencies were identified during the investigation of Incident #97172-I and the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program:	A 000		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans when needed for 2 of 3 tenants reviewed (Tenant #1 and #3). Findings follow: 1. Review of a Resident Incident Report dated 4-26-21 at approximately 5:15 to 5:20 p.m.	A 350		

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A 350	Continued From page 1	A 350		

indicated Tenant #1 eloped from the Program. The report indicated Tenant #1 had been out to the courtyard before the evening meal and Staff A checked to ensure the gate was locked. Tenant #1 watched a movie after supper, but then walked outside to the courtyard area. The report stated when she went outside she "went straight for the gate. She must have unlocked the gate herself." Tenant #1 walked along the sidewalk to the road. A tenant from the general population part of the building noticed Tenant #1 outside and brought it to the attention of the staff on her unit. Staff from the general population side of the building then notified the dementia unit staff.

Tenant #1 was brought back inside the building by two staff and the lock was put back on the gate. It was checked twice to make sure it was locked. The door to go outside to the courtyard was also locked. Tenant #1 was directed to sit down, relax and put her feet up. Tenant #1 was tearful and said she was going somewhere but did not say where she was going. Tenant #1's spouse was there a few hours earlier and she usually looked for him after he left for the day.

Review on 4-29-21 of Tenant #1's file revealed a diagnosis of Alzheimer's dementia. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The most recent service plan dated 11-23-20 reflected Tenant #1 had an activated power of attorney and had visual checks completed hourly. The service plan also reflected Tenant #1 was an elopement risk and to redirect Tenant #1 from the exit door if she went to the door. It mentioned she spoke of going to another town and in the past, she had packed her bags and wandered out of her home.

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A 350	Continued From page 2 Further record review revealed Tenant #1's service plan was not updated post elopement on 4-26-21 to reflect Tenant #1 had eloped from the courtyard and any additional interventions related to her safety. 2. Review on 5-4-21 of Tenant #3's file revealed Tenant #3 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Charting Notes dated 4-12-21 indicated Tenant #3 had an approximate 9 pound weight loss since the last assessment (90 day). Tenant #3's appetite was noted as fair but it had decreased "quite a bit from his baseline." A Vital Sign Flow Sheet reflected Tenant #3 had a 8.8 pound weight loss from 1-15-21 to 4-12-21. The tenant's service plan dated 10-20-20 reflected Tenant #3 ate independently and staff provided meal reminders as needed. Three meals were prepared and served daily. The service plan did not reflect Tenant #3's weight loss and decreased appetite, or any interventions regarding the weight loss. 3. When interviewed on 5-6-21 at 10:45 a.m. the Healthcare Coordinator confirmed the above finding.	A 350		
A 710	481-69.35(1)b Structural Requirements 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary.	A 710		

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A 710	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to maintain a building and grounds that were safe. This pertained to 1 of 1 tenant reviewed that eloped and potentially affected all tenants (census of 14). Findings follow: 1. Review of a Resident Incident Report dated 4-26-21 at approximately 5:15 to 5:20 p.m. indicated Tenant #1 eloped from the Program. The report indicated Tenant #1 had been out to the courtyard before the evening meal and Staff A checked to ensure the gate was locked. Tenant #1 watched a movie after supper, but then walked outside to the courtyard area. The report stated when she went outside she "went straight for the gate. She must have unlocked the gate herself." Tenant #1 walked along the sidewalk to the road. A tenant from the general population part of the building noticed Tenant #1 outside and brought it to the attention of the staff on her unit. Staff from the general population side of the building then notified the dementia unit staff. Tenant #1 was brought back inside the building by two staff and the lock was put back on the gate. It was checked twice to make sure it was locked. The door to go outside to the courtyard was also locked. Tenant #1 was directed to sit down, relax and put her feet up. She suffered no injuries. Tenant #1 was tearful and said she was going somewhere but did not say where she was going. Tenant #1's spouse was there a few hours earlier and she usually looked for him after he left for the day. The temperature was 80 degrees and Tenant #1 was wearing a sweater, blouse, pants and shoes.	A 710		

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A 710	Continued From page 4 2. When interviewed on 5-4-21 at 10:35 a.m. Staff A said she worked second shift in the dementia unit the day of Tenant #1's elopement. Tenant #1 had gone outside in the courtyard and she watched her out of the window and she made sure the lock was on the gate. Tenant #1 stood there for awhile and then came back inside. After supper Staff A was giving another tenant medications in the tenant's apartment and she heard her pager go off. She thought it was a visitor. She did not check her pager to see what it was and she believed the other staff working would check it. Staff B called over the radio and said that Tenant #1 was outside. She looked outside and saw there was no padlock on the gate. Staff A saw Tenant #1 and ran after her as she was on the street. Tenant #1 had crossed the street and was halfway between where the sidewalk ended and the mechanical building. Staff B reached Tenant #1 first and Staff A and Staff B walked Tenant #1 back to the building. Tenant #1 was wearing a sweater, blouse, pants and shoes. She last saw Tenant #1 before she passed medications, approximately 10 to 15 minutes before. The padlock used at that time on the gate had a code spelled with letters. Staff A's written statement indicated she ran out to the courtyard and the lock was not there. She ran to Tenant #1, who was by the road walking and holding the lock in her hands. Staff A and Staff B met up with her and then walked Tenant #1 back inside the building. Tenant #1 was very "weepy." Tenant #1 had been out in the courtyard before supper. She checked that it was locked when she was out there the first time and it was. On 5-3-21 at 3:03 p.m. Staff B said she worked second shift on the general population side on the	A 710		

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day of Tenant #1's elopement. She said it was about 5:20 p.m. when she arrived to the kitchenette dining area and was getting milk for a tenant. There was another tenant and staff at the door looking back at her. She began to walk towards them and saw Tenant #1 on the street walking north. She called on the radio to Staff A in the dementia unit and told her Tenant #1 was out of the courtyard and walking on the road. She went out of the front door and the other tenant offered to get his car. She told the other staff to try and call the DON. Staff B ran after the tenant and called her name when she was about 30 feet away. The tenant turned around and walked towards her. Tenant #1 had crossed the street and was on the right side. She was approximately 30 from the maintenance building/shed. Staff A came up and met them and they walked her back to the building. Tenant #1 did not have any injuries and was wearing a sweater, blouse, pants and shoes. She asked Tenant #1 where she was going but she did not know. The DON said to document the temperature, take her vitals and complete the incident report. Tenant #1 had the padlock in her hand and she gave it back to the staff. The gate was locked and it was checked twice.

When interviewed on 4-29-21 at 3:12 p.m. the DON said was she notified on 4-26-21 at approximately 5:45 p.m. by Staff B that Tenant #1 had left the building. She said they had reached her and brought her back to the building. She told them to obtain vital signs, complete the incident report, document the temperature and to lock the courtyard gate and courtyard door. The DON watched the video and noted Tenant #1 went out and yanked on the padlock on the gate. It looked like she pulled off the lock and walked through the gate. She left the courtyard at 5:19 p.m. and

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was back inside the building at 5:31 p.m. Tenant #1 did not sustain any injuries. After the elopement a different lock with a key was put on the courtyard gate.

The DON's written statement indicated a note was put in the communication log to not use the patio following the incident. After investigation the "lock was noted to be faulty." A new lock was put the gate on 4-27-21. Tenant #1 did not sustain any abrasions or bruises. A fax was prepared for the physician and the family and Regional Manager were notified.

3. Review of Tenant #1's file on 4-29-21 revealed a diagnosis of Alzheimer's dementia. Tenant #1 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline.

4. Observation on 5-4-21 at 11:15 a.m. indicated the approximate route Tenant #1 traveled by foot, per a phone pedometer, was .12 of a mile and 258 steps. It took approximately 3 minutes and 18 seconds to travel the approximate route at a slow pace. Possible terrain Tenant #1 traveled included the courtyard, sidewalk on the property, grass area, a gravel path and city street. The street was a two lane, north/south road, with a posted speed limit of 35 miles per hour (mph) in the area of the elopement.

Observation on 5-4-21 at 4:20 p.m. of the lock that was in place on the courtyard gate at the time of Tenant #1's elopement revealed it was a combination padlock with words. If the lock was closed and the word (code) was not reset, the lock would release even though it was latched.

5. Weather conditions provided by the State Climatologist at the time of the elopement were

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A 710	Continued From page 7	A 710		

as follows: temperature was 79 degrees, winds were from the south, southwest at 6 mph, the relative humidity was 51% and there were some low level clouds and no precipitation.

6. A Moments Exterior Door Alarm Checks document for April 2021 reflected checks were completed for two exterior doors (#16 and #17) every shift. There were no checks documented for the courtyard door or the courtyard gate and lock. The Program provided a receipt dated 4-27-21 (day after Tenant #1's elopement) for a purchase of a padlock. An additional receipt was provided for an order dated 4-28-21 for a waterproof door alarm sensor.

In summary, Tenant #1 eloped from the Program via the unsecured courtyard gate on 4-26-21. Per camera footage, Tenant #1 left the courtyard at 5:19 p.m. and two staff responded once they were alerted she was outside. Tenant #1 had the padlock to the courtyard gate in her hands when staff reached Tenant #1. The courtyard gate lock either was not properly locked or the lock did not function as Tenant #1 was able to remove the lock, carry it with her and exit the courtyard. The security of the courtyard gate did not provide the needed safety measures to maintain a safe building.