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
	S0407	A. BUILDING: _____ B. WING _____	C 09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROTARY SENIOR LIVING	620 SE 5TH STREET EAGLE GROVE, IA 50533

(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 type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 0 Number of tenants with cognitive impairment: 11 Total census: 11 There were no regulatory insufficiencies cited during the investigation of Incident #119425-I. The following regulatory insufficiency was cited during the investigation of Incident #123222-I.	A 000	**Corrective Actions Taken Immediately:** **Magnetic Lock and Alarm System Fix:** 1. **Door Realignment:** The southeast exit door was realigned and tightened to ensure it properly closes every time, preventing it from being held ajar. Intervention completed by Maintenance staff on 8/29/2024. 2. **Audible Door Alarm System Added:** Installed additional surveillance around all exits, (audible door alarms) allowing staff to monitor the doors in real-time in conjunction with the alarm system. Intervention completed by Maintenance staff on 9/5/2024. 3. **Iowa Fire Control Examination of Magnet Locks:** Iowa Fire Control on site to examine the magnetic locks on 9/4/2024. Magnetic locks were functioning appropriately.	
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, record review and staff interview, the program failed to ensure the alarm system connected to each exit door in the dementia-specific program operated properly. Findings include: On 8/30/24 the department was notified Tenant #1's eloped from the secured memory care area on the morning of 8/29/24. The temperature was 82.4 degrees Fahrenheit. The tenant was dressed appropriately with shoes on. She was identified by facility staff when she was seen at	A 635		

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A 635	Continued From page 1 10:32 a.m. on the south side of the building standing outside the dining room area with her walker. Tenant #1 was safely returned inside the building without further incident. There were no injuries noted. Record review revealed Tenant #1 was admitted to the program on 2/14/24 with a GDS of 4. When an interview was attempted on 9/04/24 at 3:04 p.m. the tenant could not recall the event. On 9/05/24 at 1:42 p.m. interview with former Staff C revealed on the morning of 8/29/24 she reported seeing Tenant #1 inside the building between 10:15 a.m. and 10:20 a.m. On 9/05/24 at 11:11 a.m. interview with Staff B revealed when she saw Tenant #1 outside the program, she went out the southeast hallway exit door to get Tenant #1 and returned her back inside the Program. The southeast door always ~~required a keypad to unlock the mag lock system and was primarily used for emergencies.~~ Staff B reported the southeast exit door was ajar/not fully shut. She did not need to enter the keycode to exit the door. She pushed on the door and it opened. Staff B reported when she and Tenant #1 returned to the southeast door to enter the building, the door was locked. It had fully shut behind her when she exited the Program to get Tenant #1. A second staff let Staff B and Tenant #1 back into the building. On 9/05/24 at 1:30 p.m. review of the southeast door's magnetic locking mechanism and the pager system used to alert staff when the door was opened revealed the system was not working properly. The southeast door was held ajar for 20 minutes to test the pager's system tied to the computer. During this time, it was realized the	A 635	**Corrective Actions Taken Immediately (continued):** 4. **Updated Door Check Policy:** Implemented new procedure to have on-coming and off-going staff check each of the exit doors together and sign off at 6AM, 2PM, and 10PM to ensure door check compliance on 9/5/2024. 5. **Staff Education with Memory Unit/RCF Staff:** Nursing Supervisor contacted department staff and educated them on new door check protocol on 9/5/2024. **Systematic Long-Term Solutions:** **All-Staff Training:** 4. Staff retraining completed 9/25/2024: o Verify door closure after each use and to respond immediately to any alarm triggers. o Ensure wandering tenants aren't left unattended near exit doors. o Table Top Elopement exercise completed. 5. Quarterly elopement training/exercises.	

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A 635	Continued From page 2 sensor was not sensing the door was open and was not sending alerts to the pagers worn by staff to alert them the door was not secure. Review of the computer system revealed the door's paging alert system recognized this door as being shut when it was in fact held open and not secure. The pagers that alerted staff to the door being open showed the alarm was cleared automatically while the door remained ajar. In addition, it had been discovered the magnetic lock on the door failed the morning of 8/29/24. It could not be determined the reason it occurred but was thought to have been a combination of the hot and humid weather and the older door's frame that required adjustment for a tighter fit. On 9/05/24 at 2:31 p.m. maintenance staff reported the southeast exit door has been realigned and tightened ensuring it closed properly at all times following the incident on the morning of 8/29/24. ~~On 9/09/24 at 4:30 p.m. the Administrator confirmed these findings.~~	A 635	**Measures to Ensure the Problem Does Not Recur:** 1. **Weekly Maintenance Inspections:** Maintenance staff will conduct weekly inspections of the magnetic locks, door mechanism, alarm and pager systems to ensure continuous functionality. 2. **Door Security Procedures:** New protocols were established requiring staff to physically check and verify that all doors are securely locked during every shift change, Implemented on 9/5/2024. 3. **Staff Training:** All employees have been further trained to monitor exits closely, especially during high-traffic times, and ensure immediate intervention if a tenant is observed near the exit doors. Implemented on ~~9/25/2024.~~ **Monitoring Plan:** 1. **Real-Time Alarm Monitoring:** The facility has installed additional surveillance around all exits, allowing staff to monitor the doors in real-time in conjunction with the alarm system. 2. **Quarterly Audits:** Audits of the alarm and door systems will be performed every quarterly to ensure long-term compliance. **Completion Date:** All corrective actions have been completed as of **September 9, 2024.**	

✓ 3.31.25