

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0443	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/03/2024
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GRAND LIVING AT TOWER PLACE MC

**540 S 51ST STREET
WEST DES MOINES, IA 50265**

(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: 1 Number of tenants with cognitive impairment: 33 Total census: 34 No regulatory insufficiencies were cited during the investigation of Complaints 118877-C, 121223-C, 118029-C or 121854-C. The following regulatory insufficiencies were cited during the investigation of Incident 121624-I, Complaint 118087-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the Program failed to consistently follow established policies regarding door alarms and medications. This pertained to 1 of 1 tenants reviewed who eloped (Tenant #1) and 1 of 1 tenants whose medications were found unsecured in the medication cart (Tenant #5). Findings follow:	A 150	In accordance with regulation 481.67.2(3)a 67.2(3) The program shall follow the policies and procedures established by the program. 1. Elopement training was completed on 06/12/24. New employee training is completed in on-boarding that is completed within the 1st 30 days of employment during orientation. Staff also take a quiz and sign off acknowledgment and understanding of how to respond to door alarms. We are	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 150	Continued From page 1 1. Record review on 8/20/24 revealed an Incident Report (IR) dated 6/5/24 at 2:42 pm documenting a gentleman and his son brought Tenant #1 back to the building from a daycare located next door. Further review revealed a Progress Note (PN) dated 6/7/24 (identified as a late entry for 6/5/24 at 4:00 p.m.). The note said the front desk notified the Director of Health and Wellness (DOHC) a young man and his son found Tenant #1 at the daycare and walked her back. No injuries were noted. Observations on 8/21/24 revealed the adjacent daycare was located approximately 40 to 50 yards through the Program's parking lot. According to wunderground.com at the time the tenant was outside it was 84 degrees with no precipitation. When interviewed on 8/21/24 at 2:25 the Director of Facets (DOF) explained he had been an activity assistant when the incident occurred. He said he assisted with tenant care and supervision on 6/5/24. He described the environment as unsettled as tenants were having personal conflicts. While attempting to calm the tenants he noticed Tenant #1 wandering up and down the hallway. He admitted he heard the door alarm go off and went to the door and listened, but did not check to see if anyone went thru the door. After a few minutes he told Staff A he did not see Tenant #1. Staff A initiated a search. He checked rooms in the Lavender unit and notified the Illuminations Director by text. He said he was notified that someone had brought Tenant #1 back to the front desk of the Program. The DOF said he had not yet received training regarding elopement or how the door alarm operated at the time the incident occurred.	A 150	conducting quarterly elopement drills. Deficiency has been corrected as of 06/12/24.		

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A 150	Continued From page 2 When interviewed on 8/21/24 at 1:30 p.m. Staff A said she worked on the Lavender unit on the day of the incident. She usually worked on the Monarch wing but they needed someone to help cover on Lavender as two ladies had a conflict that escalated and had affected many of the tenants. Staff A said Tenant #1 had a history of wandering in the afternoon. She said the Director of Facets told her he had heard the alarm but didn't see Tenant #1. Staff A started a search for Tenant #1 but did not locate her. Record review on 8/22/24 revealed the DOF's written statement dated 6/10/24. He noted he entered the Lavender unit on 6/5/24 at 2:23 p.m. He believed Tenant #1 attempted to open the stairway door unwitnessed. He looked down the hall and went to the door and listened at 2:31 p.m. but did not open the door to search for Tenant #1. He communicated to Staff A he didn't see Tenant #1. Staff A started a search for Tenant #1 but did not locate her. He texted his supervisor at 2:44 p.m. Record review on 8/22/24 revealed Tenant #1's service plan in effect at the time of the incident was dated 8/28/23 and identified Tenant #1's wandering behavior (effective date of 8/1/23). The plan said staff should redirect Tenant #1 away from exit doors daily and as needed to manage wandering and prevent elopement. Tenant #1's diagnosis included Alzheimer's disease, unspecified. Her cognitive evaluation dated 10/6/23 revealed her Global Deterioration Scale (GDS) scored four signifying moderate cognitive decline (mild dementia). She resided in the secured memory care unit. Further review revealed the Program's policy entitled Dementia Specific Exit Doors dated	A 150			

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A 150	Continued From page 3 11/1/20. The Policy directed staff to promptly check the door when the alarm sounds. They were to check thoroughly inside and outside and account for all tenants. During the exit on 12/3/24 at 11:15 a.m. the administrative staff confirmed staff failed to follow the Program's policy. 2. Observations on 8/26/24 at 4:30 p.m. revealed two medications in a cup in the top drawer of the medication cart. When questioned, the staff administering medication said they were probably refused by a tenant. She called the Assistant Director of Wellness (ADOHW) who confirmed the medications had been refused by Tenant #5. He directed the staff to dispose of the medications in a Biohazardous waste container. She attempted to dispose in Biohazardous container on the unit but could not locate the container. She found a Biohazardous container on the Assisted Living side of the building and placed the medication in the container. When interviewed on 8/28/24 at 11/18/24 the ADOHW said Tenant #5 had refused her medications on 8/25/24 during 8:00 p.m. medication administration. Record review on 8/28/24 revealed the Program's Refusal of Medications poicy dated 8/21/24. The policy directed staff to dispose of refused medications in a Biohazardous Waste Container. Record review on 8/28/24 revealed Tenant #5's Medication Administration Record (MAR) for August. The ADOHW documented Tenant #5 refused her 8:00 p.m. Memantine 5mg and Quetiapine 50 mg.	A 150	2. ADOHW has been educated on immediate disposal of refused medications. Continued mentoring of ADOHW and training on the rules and regulations. DOHW is continually monitoring documentation and continuing with training ADOHW. Regulatory insufficiency corrected 08/29/24.		

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A 150	Continued From page 4 At 11:40 a.m. on 8/28/24 the DOHC confirmed the ADOHW should have disposed of the medication per the policy at the time of the incident.	A 150		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure physician orders were followed for 1 of 3 former tenants reviewed (Tenant C9). Finding follows: Record review on 8/28/24 revealed Tenant C9's progress notes dated 5/21/24 revealed new orders were received for weekly weights for four weeks. Further review revealed Tenant C9's weight document lacked documentation of weights for the weeks of 5/21/24, 5/28/24 and 6/10/24. The Program failed to follow Tenant C9's physician's orders. During the exit on 12/3/24 at 11:15 a.m. the administrative team confirmed the above findings	A 285	In accordance with regulation 481.67 .5(2)f(4) 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. Meeting set up to to review medication administration and proper documentation per policy and procedure with staff on 02/26/25. DOHW and ADOHW to review eMAR weekly to ensure that medications are being administered at proper times and that physician, ARNP and PA orders are being followed by staff per eMAR. Regulatory insufficiency to be completed by 03/01/25.	

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A 520	481-69.29(2) Staffing 69.29(2) In lieu of providing access to a personal emergency response system, a program serving one or more tenants with cognitive disorder or dementia shall follow a system, program, or written staff procedures that address how the program will respond to the emergency needs of the tenant(s). This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the Program failed to consistently follow the Personal Emergency Response policy/procedure. This pertained to 3 of 3 current tenants (Tenants #1, #3 and #4) and 3 of 3 former tenants reviewed (Tenants C7, C8 and C9). Finding follows: 1. Record review on 8/27/24 revealed the Program's Staffing - Personal Emergency Response System policy dated 11/1/20. The policy directed staff to check on tenants as indicated in the service plan. Further review revealed Tenant #1's service plan directed staff to check on Tenant #1 during the night. The Program failed to include directions to staff for when or how often to check on Tenant #1 in order to address or respond to emergency needs other than during the night. On 6/3/24 at approximately 2:20 p.m. Tenant #1 eloped and a father and his son from the daycare located next to the Program returned her to the Program. Record review on 8/28/24 revealed Tenant #1's Master Assessment (MA) dated 10/6/23 revealed her Global Deterioration Scale (GDS) score measured 4 signifying moderate	A 520	In accordance with regulation 481.69.29 (2) 69.29(2) In lieu of providing access to a personal emergency response system, a program serving one or more tenants with cognitive disorder or dementia shall follow a system, program, or written staff procedures that address how the program will respond to the emergency needs of the tenant(s). 1. DOHW has met with Infomatics nurse and assessment to be updated within 30 days to include each resident with a GDS of 4 or greater a monitoring system to respond to emergency needs during nonscheduled service times throughout the entire day. They will pull to the service plan to be reviewed with resident and POA when signing service plan. To be completed within 30 days.	

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A 520	Continued From page 6 cognitive decline. Under the safety and evacuation section, it was documented the tenant resided on memory care and a pendant was available upon request. 2. Record review on 8/27/24 revealed the Program failed to include directions to staff in service plans of Tenants #3, #4, C7, C8 and C9 per the Program's Personal Emergency Response policy in order to respond to emergency needs. Review of Tenant #3's MA dated 6/3/24 revealed her GDS score measured 5 signifying moderately severe cognitive decline. Under the safety and evacuation section, it was documented the tenant resided on memory care and a pendant was available upon request. Tenant #3's service plan, effective date 12/11/23, failed to include direction to staff for when or how often to check on Tenant #3 in order to address or respond to emergency needs. Review of Tenant #4's MA dated 1/8/24 revealed her GDS measured 5 signifying moderately severe cognitive decline. Under the safety and evacuation section, it was documented the tenant resided on memory care and a pendant was available upon request Tenant #4's service plan, effective date 1/8/2, failed to include direction to staff for when or how often to check on Tenant #4 in order to address or respond to emergency needs. Review of Tenant C7's MA dated 11/17/23 revealed his GDS measured 4 indicating moderate cognitive decline. Under the safety and evacuation section, it was documented the tenant resided on memory care and a pendant was available upon request. The tenant's service plan,	A 520	2. DOHW has met with Infomatics nurse and assessment to be updated within 30 days to include each resident with a GDS of 4 or greater a monitoring system to respond to emergency needs during nonscheduled service times throughout the entire day. They will pull to the service plan to be reviewed with resident and POA when signing service plan. To be completed within 30 days.	

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A 520	Continued From page 7 effective date 2/27/24, failed to include direction to staff for when or how often to check on Tenant C7 in order to address or respond to emergency needs. Review of Tenant C8's MA dated 2/12/24 revealed his GDS score measured 5 indicating moderately severe cognitive decline. Under safety and evacuation, the Program stated tenant resided on memory care and pendant available upon request. Service Plan effective date 3/12/24 failed to include direction to staff for when or how often to check on Tenant C8 in order to address or respond to emergency needs. Review of Tenant C9's MA dated 4/8/24 revealed his GDS score measured 5 indicating moderately severe cognitive decline. Under safety and evacuation, the Program stated tenant resided on memory care and a pendant available upon request. The MA also noted Tenant C9 did not use a pendant. The tenant's service plan, effective date 4/8/24, included a task to check Tenant C9's pendant. The plan failed to include direction to staff for when or how often to check on Tenant C9 in order to address or respond to emergency needs. During the exit on 12/3/24 at 11:40 a.m. the administrative team confirmed the Program failed to follow the personal emergency response policy.	A 520			