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 11/15/2022

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 type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 45 Number of tenants with cognitive disorder: 1 Memory Care Unit Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 34 TOTAL census of Assisted Living Program for People with Dementia: 80 No regulatory insufficiencies were cited during the investigation of Complaints #108492-C or #108781-C. The following regulatory insufficiencies were cited during the investigation of Incident #108535-I and Complaint #108537-C.	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 interview and record review the Program failed to follow established policies and procedures regarding elopement. This pertained to 1 of 1 tenants reviewed as a result of Incident #108535-I (Tenant #1). Findings follow:	A 150		

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A 150	Continued From page 1 Record review on 10/27/22 of Tenant #1's file revealed Tenant #1 was admitted to the memory care unit on 10/21/22. The Global Deterioration Scale dated 10/21/22 revealed a score of 6 and indicated severe cognitive decline. Continued record review failed to produce a service plan or any documentation regarding the needs of Tenant #1 (see Iowa Administrative Code 481-69.26(2)). Additional record review revealed Incident Report, dated 10/23/22, documented video from the Program's camera showed Staff A leaving 500 memory care hall, crossing a foyer and entering 400 memory care hall. Staff A failed to notice Tenant #1 behind her. Tenant #1 proceeded to exit out the door. She required hourly checks and the last documented check occurred at 1:45 p.m.. The Police Department notified the Program they picked up Tenant #1 and would return her around 3:00 p.m. She wore long pants, a jacket, and appropriate footwear. She denied any injuries and none were noted. Camera footage captured Staff A open the door of 500 memory care hall, exited without looking behind her and proceeded to cross the foyer and enter 400 memory care hall. Tenant #1 appeared to be approximately two feet behind Staff A as they exited 500 memory care hall. Tenant #1 looked at Staff A and proceeded to walk out the back door. Observations revealed the Program was located on Beaver Road, a two-lane road with a center turning lane with a speed limit of 30 mph. and approximately a quarter mile from Douglas Avenue. According to Wunderground.com, the weather in the Des Moines, Iowa vicinity on 10/23/22 at 2:54	A 150		

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A 150	Continued From page 2	A 150		

p.m. was mostly cloudy and windy with a temperature of 81 degrees Fahrenheit (F) and winds out of the South - Southeast at 28 miles per hour.

Review of the door alarm report revealed the initial door alarm went off at 2:35 p.m. and staff cleared it at 2:49 p.m.

On 10/27 the Healthcare Coordinator provided a screen shot of the door alerts on her cell phone. The time of the alerts were 2:44 p.m. and 2:48 p.m.

Record review revealed the Program's Elopement Policy/Visual Check Process/Exit Alarms policy instructed staff must check doors immediately when they received an alert on the iPads and ensure all residents were accounted for.

When interviewed on 10/27/22 at 1:47 p.m. the Healthcare Coordinator confirmed she received alerts on her phone corresponding with the door Tenant #1 exited out of and stated, "I get alerts all the time so what I am supposed to do about that?" She reported she received no training for on-call duties.

Review of the Healthcare Coordinator's training records, dated 6/30/22, included "On-call Responsibilities" and "Clarification of Expectations", which included 24/7 on call responsibility.

When interviewed on 10/27/22 at 10:42 a.m. Staff A confirmed she went from 500 hall to 400 hall and failed to look behind. She stated she was unaware Tenant #1 followed her out the door. She reported iPads were available in the memory care but usually left them on the counter because all

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A 150	Continued From page 3 tenants received hourly safety checks and they would chart them when completed. She stated she did not hear the alert from the iPad after she entered 400 hall. Staff A stated she received no information regarding her history of elopement and no service plan was available. When interviewed on 10/27/22 Staff B reported she assisted a tenant in another area of the building and could not leave. She recognized the alarm for the door downstairs and assumed the memory care staff would take care of it. Staff B checked the door after she was finished, did not observe anyone, and failed to initiate a head count. When interviewed on 10/27/22 at 12:38 pm Staff C stated the door alarm wasn't to be reset until all tenants are accounted for. When interviewed on 10/27/22 at 11:07 a.m. Staff D said she worked in the assisted living portion and received a door alarm alert on her iPad but was bust assisting a tenant she could not leave unattended. She confirmed at times this door will go off and thought it might have been a staff or family member. She recalled she reset the door alarm after completing a visual check of the outside and failed to conduct a head count before resetting the alarm. The Registered Nurse confirmed findings on 10/27/22 at 9:27 a.m.	A 150		
A 355	481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be	A 355		

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A 355	Continued From page 4 developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record reveiw the Program failed to develop a servcie plan prior to occupancy for 1 of 1 tenants (Tenant #1) reviewed as a result of Incident #108535-I. Findings follow: Record reveiw on 10/27/22 of Tenant #1's file revealed the Occupancy Agreement signed 10/21/22. No service plan could be located. The Registered Nurse confirmed this on 10/27/22 at 9:27 a.m.	A 355		