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 11/17/2021

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 Assited 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 onsite review. General population: Number of tenants without cognitive disorders: 43 Number of tenants with cognitive disorders: 2 Memory Care Unit: Number of tenants without cognitive disorders: 0 Number of tenants with cognitive disorders: 30 Total: 75 No regulatory insufficiencies were cited during the investigation of complaints #98769 and 99631 No regulatory insufficiencies were cited during an infection control review. The following regulatory insufficiency was cited during the investigation of incident #100073	A 000	See Attached POC 2/8/22	
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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the program failed to ensure a safe environment when a tenant eloped from the program. This affected 1 of 1 tenant (Tenant #1) reviewed as a result of investigation #100073-I. Findings follow:	A 710		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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Record review on 11/9/21 revealed a program incident report dated 9/21/21. The report noted, at approximately 7:30PM, a call was received from the RA (Resident Assistant) to the program RN to report a neighborhood couple from behind the program rang the doorbell. The couple were bringing back Tenant #1. Tenant #1 was wearing a sweatshirt, sweatpants and tennis shoes. A skin check was performed on the Tenant and no scratches were noted. He was able to move all extremities without difficulty and no bumps or abrasions were noted. When asked, the tenant denied discomfort or pain. Staff were asked to push on an exit door to see if it opened and it did. Doors between the 500 and 600 halls were closed to prevent reoccurrence. The report stated, "The Director had checked door today at 1430 on safety check and it was working properly at that time. Camera reviewed with resident visualized walking down the hallway from 400 hall down the street, the family (neighbors) meeting him and walking back with him. Not leaving visual contact of the cameras."

According to time and data.com the temperature in Des Moines, Iowa on 9/21/21 at 6:00 PM was 68 Degrees and the sun set at 7:12PM.

Record review revealed Tenant #1 was a 78-year-old male living on the program's memory care unit. Diagnoses included Dementia in other Diseases Classified Elsewhere without Behavioral Disturbance, Parkinson's Disease, Acute Poliomyelitis, Unspecified, Delusional Disorders, Gout, Suicidal Ideations. He had a GDS score of 6. Tenant #1's service plan dated 10/19/21 noted Focus - Mobility, date initiated 3/3/21 with interventions "Unable to exit building without total assistance; Focus - Safety, date initiated 3/3/21 with interventions "24 hour supervision and visual

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A 710	Continued From page 2	A 710		

checks in Memory Care, Resident prefers to sit outside, Resident prefers to walk outside." All dates initiated on 3/3/21; Focus - Mobility, date initiated 3/3/21 with interventions " Ambulation has a history of falls, Assistive needs assistance of an assistive device: wheeled walker, Assistive Device: Remind to use assistive device if seen without, Escort needed to/from activities and/or dining room due to poor memory on where to go."

On 11/9/21, during a tour, with the director, the gate leading to the memory care program patio was malfunctioning. The director was unable to open the gate. The maintenance person came with a different code to the gate and opened the gate. Upon attempting to reenter, the director attempted to open the gate, with the new code, and the gate did not open. The maintenance person eventually was able to open the gate. On 11/16/21, the director stated the patio gate was not malfunctioning on 11/9/21. He explained the gate code leaving the gate was different from the code entering the area.

Interviews with the Director on 11/9, 10, 16/21 revealed the video from the cameras indicated a family, visiting a memory care tenant, using the back gate, to enter memory care patio. The Director said the camera showed tenant #1 on the patio when the family entered the patio and the camera showed him walking, with his walker, down the ramp towards Amick Street. He noted there was a blackened area of the video and he was unable to actually see tenant #1 actually leave from the patio via the patio gate. The video only showed him on the patio and then going down the ramp. The Director stated the video was no longer available as it was deleted after one month. The Director said, unbeknownst to

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him, a number of family members often used the back gate to enter the memory care program as they had the code to open the gate. The Director surmised, on the evening of the incident, a visiting family might have left the gate open and tenant #1 left through the open gate. He offered there were three families visiting tenants at the time of the incident. He noted he had no luck when he contacted the families to see if they witnessed tenant #1 leaving the area. The Director offered after the incident the patio gate code had been changed, families were notified they could not have the code to the patio gate and staff were retrained on the elopement policy.

An interview on 11/9/21 with RA A revealed she was not working on the memory care unit at the time of the incident. She offered that she had heard about tenant #1 leaving the program on 9/21/21. Staff A said she assumed a family member entered through the rear gate leading to the memory care program patio and the tenant left through the gate. Staff A noted, in the past, families had access to the patio gate and since the time of the incident, families no longer had access to the gate. She stated visitors should enter through the front entrance.

An interview on 11/9/21 with RA B revealed she was not working at the time of the incident. She stated tenant #1 might have gone out the staff entrance, which was located not far from the tenant's apartment. She offered the tenant also could have gone out to the patio and the gate was malfunctioning. Staff A noted in the past the gate had malfunctioned. She also offered staff were to always have their tablets in their possession and perhaps they did not have their tablets with them, and as a result were not alerted to an alarm.

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An interview on 11/9/21 with RA C revealed she had only been working at the Program for a month and a half. She stated visitors to the memory care program had to make an appointment with the Administrative Assistant if they wished to enter the Program from the rear entrance leading to the memory care program; otherwise, visitors were to enter through the main entrance.
An interview on 11/15/21 with RA D revealed at the time of the incident he was working in the 700 area performing cares for a tenant. He said he answered a knock on the door to the employee entrance at approximately 7:00PM. He stated a woman was at the door with tenant #1. He then took tenant #1 to his room and notified the RN. He noted the tenant did not appear to be injured. Staff D added he then checked all entrance/exit doors and all alarms were in working order. He said, around the time of the incident, the only visitors, in his area, to the memory care program were tenant #1's family. RA D recalled they dropped of fruit for the tenant, came in through the main entrance and did not go to the memory care program. He offered he was still trying to figure out how the tenant was able to leave the program. Staff D described tenant #1 as usually wanting to stay in his room, did not usually go outside and he did not have a wanderguard.

An interview on 11/15/21 with RA E revealed she was working on the general population program at the time of the incident. She recalled at approximately 7:00PM, she heard on the radio Staff D explaining tenant #1 being returned from the outside to the memory care program. She remembered it was dark outside. Staff E said she had worked with tenant #1 before and described tenant #1 as not a wanderer and usually stayed in his room. She offered many

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time the tenant preferred to eat his meals in his room. Staff E stated the only time families had access to the patio gate was when they were moving a family member in or out. She was not aware of the patio gate ever malfunctioning and added if a tenant tried to leave an exit area an alarm would go off and the alert would be on their tablet.

An interview on 11/16/21 with RA F revealed she was assigned to work with Tenant #1 on the second shift on 9/21/21. She stated she was working with another tenant, in the tenant's apartment, at the time of the incident. RA F remembered at approximately 7:00PM RA D told her a neighbor had returned tenant #1 to the program and was in his apartment. She recalled she went to his apartment and asked the tenant why he left the program. She said the tenant told her "I'm so sorry I'll never go out again!" She added he told her he'd never go out again numerous times. RA F offered she had been visually monitoring Tenant #1 at least once an hour. She noted the tenant usually stayed in his room. RA F volunteered she had no idea how the tenant left the program. She thought he might have left because his sister did not visit him and he was going to visit her. RA F said the 500 emergency exit alarm went off around the time the tenant was brought back to the program; however, a check outside the 500 door revealed no one in the area. RA F explained the program had employed her for four years and in that time she had never heard of a tenant eloping from the program. She also stated she had never heard of or witnessed the alarm doors or patio gate malfunctioning. RA F said when a visiting family member wanted to enter the program from the rear of the building; they would have to contact the administrative assistant to make an

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A 710	Continued From page 6 appointment. An interview on 11/17/21 with the Director of Nursing (DON) revealed she received a call from, she thought, RA D. The RA informed her community neighbors brought tenant #1 to the employees' entrance in the rear of the building. She stated she assessed the tenant via face time and noted no injuries. The DON remarked the 500-exit door alarm was activated at approximately 7:35PM. Staff reportedly immediately looked out the door and did not see anyone. She offered it was possible tenant #1 went out the 500 door, as his apartment was close by the 500 exit door. She thought the tenant could have walked over to the patio. She added no one actually knew how the tenant left the program. The DON described tenant #1 as quiet, usually stayed in his room and had no history of elopement. The DON said there had been a few time times when alarms malfunctioned (went off) however they were immediately fixed. She was aware some families had the code to the back patio gate and assumed they had the code so they could visit tenants outside during Covid.	A 710		

ok
2/15/22

Edencrest™
AT BEAVERDALE

Edencrest at Beaverdale
3410 Beaver Avenue
Des Moines, Iowa 50310

Date: 2/8/2022

Complaint Intake #: Incident # 100073

Plan of Correction (POC) Submitted For:
- Investigation Date: 11/9/21 to 11/17/21

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.

Regulatory Insufficiency: This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the program failed to ensure a safe environment when a tenant eloped from the program.

i. **Program POC:**
1. Elements detailing how insufficiency was corrected for residents:
    a. Codes for each gate on both sides has been changed.
    b. Communication sent to all families regarding only entering the community through the front door.

2. Actions program taking to protect tenants in similar situations:
    a. Codes for each gate on both sides has been changed.
    b. Communication sent to all families regarding only entering the community through the front door.
    c. Increased the spring tension on hinges to insure a fast close rate.

3. Measures taken to ensure problem does not recur:
    a. Implementation of at a minimum Quarterly elopement drills in December.
    b. Re-training of all staff regarding our elopement policy.

4. Program plans to monitor performance to ensure compliance:

a. Director or designee will monitor keypads and courtyard gates, weekly, monthly, and as needed, as determined by the Director

Christopher Beach

Christopher Beach, Director of Edencrest at Beaverdale

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.