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
	S0445	A. BUILDING: _____ B. WING _____	C 11/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STIRLINGSHIRE OF CORALVILLE MC	**1140 KENNEDY PARKWAY CORALVILLE, IA 52241**

(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: 1 Number of tenants with cognitive disorder: 1 Total census: 2 No deficiencies were cited during the onsite infeciton control survey. The following regulatory insufficiencies were cited during the initial certification conducted to determine compliance with certification for a Dementia-Specific Assisted Living Program and the investigation of Incident # 100419-I and Incident # 100370-I.	A 000		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the Program failed to provide adequate and appropriate services for 1 of 2 tenants reviewed (Tenant #1). Findings include: A review of Tenant #1's record on 10/27/21 revealed an admission date of 9/30/21. Tenant #1	A 160	The Plan of Correction is attached.	

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

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A 160	Continued From page 1	A 160		

had a diagnosis of unspecified dementia with behavioral disturbance. He scored a 5 on his most recent Global Deterioration Scale (GDS) dated 9/22/21 which indicated moderately severe cognitive decline. Tenant #1's service plan implemented on 9/30/21 indicated a history of wandering and elopement from previous homes. He received scheduled safety checks daily which were generally spaced 2 hours apart.

An incident report dated 10/22/21 revealed at approximately 5:45 PM, staff could not locate Tenant #1 in the Program. The building and grounds were searched with no results. Staff called 911 for assistance. Staff also contacted the Executive Director and Clinical Registered Nurse (RN) upon discovery of the missing tenant. Staff said they did not think they heard the alarm while sitting in the nurses' station. The staff noted the door alarm light located in the nurses' station was set to off when it previously been on. The tenant was located by the police department and returned to the building at 5:58 PM. The incident report documented the tenant had received no injuries. The form had an area for vital signs which was not completed. In addition the report was not signed or dated by the person who completed it.

On 10/27/21 at 10:48 AM the Executive Director stated the police returned Tenant #1 to the facility. The police stated the tenant was picked up by someone driving from the ALP/Independent Living complex area and driven to the front of the high school two miles away where he was dropped off. The video showed he walked out the door of the memory care unit at 5:29 PM. The police picked the tenant up in front of the high school and returned him to then facility at 5:58 PM. The police indicated he was driven to where

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A 160	Continued From page 2 he was picked up. Information provided by the Program revealed the temperature at the time the tenant left was 46 degrees. He wore sweatpants, a sweatshirt, tennis shoes and a stocking cap when he left. On 10/27/21 at 11:15 AM, the Clinical RN stated she was contacted by Staff B on 10/22/21 that Tenant #1 was missing. The Executive Director was also contacted and was going to the Program. The Clinical RN stated she did not go in as she lived 45 minutes away and knew others were headed there. After the tenant was returned by police, Staff E told the Clinical RN she assessed him when she got him ready for bed and had not seen any injuries. On 10/28/21 at 3:00 PM, the Clinical RN confirmed she had not come in and completed an assessment of the tenant. In addition, evaluations for the significant change of elopement from the Program were not completed until 4 days later. The Clinical RN said since the tenant's 30 day evaluations were due on 10/26/21, she decided to wait to do the significant change evaluations until that time. On 10/27/21 at 10:30 AM, Staff A stated he was the person working on the night of 10/22/21 and was in charge of Tenant #1's safety. This was his first time working with the tenant. Staff A recalled Tenant #1 was pacing that night. After supper was completed, he went into the staff office to do computer work. The office contained a glass window to view the common areas and an automated closed door. Staff A noticed that around 5:30 PM, he couldn't see Tenant #1 in the common areas. Staff A looked in Tenant #1's apartment but he wasn't there. Staff A searched other areas of the Program but could not find him. Staff A asked Staff B, Staff I, and Staff J who	A 160		

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A 160	Continued From page 3	A 160		

were all in the connected assisted living program if they had heard an alarm or saw Tenant #1, but they had not. He then searched outside and around the neighborhood. Staff B contacted the Executive Director and 911. Staff A stated at first that he had not heard the alarm go off at all. He later said while in the staff office, he might have heard a noise but was not sure what it was and thought it could have been a doorbell. Staff A added he noted the door alarm light was green when he went to ask the assisted living staff if they had seen Tenant #1. Staff A stated it hadn't registered with him at the time the green light meant the door was unlocked or had been released.

On 10/28/21 at 1:10 PM, Staff B stated she was training Staff I on 10/22/21. At some point between 5:00 PM and 5:30 PM on 10/22/21, Staff A came over to the assisted living program and asked if they had seen Tenant #1. Staff B stated they had not. They had been assisting with the dinner service and had not seen him or heard an alarm. Staff B stated she had seen Tenant #1 touch the door push bar before and make the alarm beep but he had never opened the door before that she was aware of.

On 10/28/21 at 2:00 PM, Staff I stated he was in training and worked back and forth between the memory care program and the assisted living program on 10/22/21. Staff I stated he last observed Tenant #1 in the memory care program at around 4:30 PM or 4:45 PM when he served him dinner. Staff I stated he helped in the assisted living program and served dinner there until approximately 5:30 PM. At 5:30 PM, Staff I stated he went to the memory care to use the restroom and noted Tenant #1 not pacing around as usual. Staff I questioned Staff A about this. He

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A 160	Continued From page 4	A 160		

then left the memory care and went back to the assisted living. Several minutes later, Staff A came to the assisted living and asked Staff I and Staff B if they had seen Tenant #1. They stated they had not. Staff B contacted 911 and Staff I assisted in searching inside and outside of both programs.

On 10/27/21 at 1:15 PM, Staff J stated she was washing dishes at around 5:30 PM on 10/22/21 when Staff A popped in and asked if she had seen Tenant #1 or if she had heard the alarm go off. Staff J stated she had not.

On 10/27/21 at 11:01 AM, the Maintenance Director stated he came in to the Program on 10/22/21 as he was called by the Executive Director. He immediately checked the memory care exit door and the door alarm worked properly. This meant the alarm had to have gone off when Tenant #1 exited the Program. The Maintenance Director stated after reading up on the alarm, he realized the alarm would have gone off on 10/22/21 for exactly 2 minutes after the tenant exited and then would have shut off and reset. He changed the alarm the next day to stay on permanently if triggered until staff turned it off using a key. The Maintenance Director also reviewed the hallway camera footage which showed Tenant #1 leaving the memory care program at 5:29 PM.

On 10/27/21 at 3:15 PM, the Executive Director stated she implemented 15 minute checks on Tenant #1 immediately upon his return and for staff to only do paperwork in areas where Tenant #1 was and not the office. All staff were notified of this change the next day. The Executive Director also indicated staff were no longer to allow Tenant #1 out of their sight in common areas unless

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A 160	Continued From page 5 another staff was available to take over supervision until a second safety measure/alert could be added to all of the Program's exit doors. On 10/27/21, the Alarm Response policy for the Program was reviewed. The policy revealed the following: 1.) Check to determine the location of the alarm that is sounding. This will indicate the door that has been opened. (the memory care Program has 2 exit doors) 2.) Staff must immediately respond to all door alarms. On 10/28/21 at 9:50 AM, the surveyor sat in the staff office and had the Clinical RN trigger the door alarm. The surveyor could hear the muffled door alarm. On 11/1/21 at 4:00 PM, the Executive Director confirmed the above findings.	A 160		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure 2 of 6 staff reviewed had completed the two hours of training required for the identification and reporting of dependent adult abuse within six months of employment as required by Chapter 235B. (Staff A, C) Findings include:	A 380		

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A 380	Continued From page 6 Chapter 235 B requires that employees complete two hours of training relating to the identification and reporting of Dependent Adult Abuse within six months of initial employment and at least two hours of additional dependent adult abuse identification and reporting training every three years. On 10/28/21, the following was discovered during a personnel record review: - Staff A's date of employment was 3/22/21. A record of Staff A completing the two hours of training required for the identification and reporting of dependent adult abuse within six months of employment could not be located. - Staff C's date of employment was 4/12/21. A record of Staff C completing the two hours of training required for the identification and reporting of dependent adult abuse within six months of employment could not be located. On 11/1/21 at 4:00 PM, the Executive Director confirmed the above finding.	A 380		
A 465	481-69.28(5) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure orientation training was	A 465		

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A 465	Continued From page 7 provided regarding safe food handling as required for 6 of 6 staff reviewed responsible for food service (Staff A, C, D, E, F, H). Findings include: On 10/28/21, the following was discovered during a personnel record review: - Staff A's date of employment was 3/22/21. A record of Staff A completing an orientation on sanitation and safe food handling could not be located. - Staff C's date of employment was 4/12/21. A record of Staff C completing an orientation on sanitation and safe food handling could not be located. - Staff D's date of employment was 5/17/21. A record of Staff D completing an orientation on sanitation and safe food handling could not be located. - Staff E's date of employment was 6/8/21. A record of Staff E completing an orientation on sanitation and safe food handling could not be located. - Staff F's date of employment was 6/28/21. A record of Staff F completing an orientation on sanitation and safe food handling could not be located. - Staff H's date of employment was 8/30/21. A record of Staff H completing an orientation on sanitation and safe food handling could not be located. On 11/1/21 at 4:00 PM, the Executive Director confirmed the above finding.	A 465		

STIRLINGSHIRE
OF CORALVILLE

ASSISTED LIVING | MEMORY CARE

January 20, 2022

Department of Inspections and Appeals
Attn: Deb Dixon
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Dixon:

On behalf of Stirlingshire of Coralville MC, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Monitoring Report dates 11/1/2021. 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 insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of state law.

Tenant Rights A 160

1. Elements for how the Program will correct each regulatory insufficiency
    - Staff was re-educated on the Alarm Response/ Missing Tenant policy
    - Nursing staff was re-educated on the appropriate assessment process and documentation process upon return of a tenant that has eloped
    - A partnership with the Program and the ICPD called "Project Lifesaver" was put into place for the tenant that had eloped. This is a tracking device that can locate the tenant by the ICPD if it were to happen again until the Accutech system is put into place
2. What measures will be taken to ensure the problem does not recur?
    - A new Accutech system is being put into place that will lock the doors as the tenant approaches any of the exit doors. If a tenant approaches the door, or tries to exit, the system will notify the staff that is working

3. How does the program plan to monitor performance to ensure compliance?

- On-going education to staff on the alarm response
- Monitoring of the new Accutech system.

4. The date by when the regulatory insufficiency will be corrected
- The insufficiency will be corrected by 2/17/2022

Staffing A 380

1. Elements for how the program will correct each regulatory insufficiency

- Dependent Adult Abuse Training will be required to be completed on the 1st day of employment. If the new employee has completed it prior to hire at Stirlingshire, they must provide the certificate.
- All current employees have completed this DAA training with a copy of the certificate in their file
- If staff member is out of compliance, they will be removed from the schedule until education is completed

2. What measures will be taken to ensure the problem does not recur?
    - A new hire checklist of all required education has been created

3. How does the program plan to monitor performance to ensure compliance?
    - A spread sheet has been created and will be monitored to endure all initial education is completed, and any re-education is noted with the date it is required by

4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be corrected by 2/17/2022

Food Service A 465

1. Elements for how the program will correct each regulatory insufficiency

    - Dining, Nutrition and Food Safely is now a required module of training for new staff members in their first day of training
    - All current staff members have completed this training via Educare

2. What measures will be taken to ensure the problem does not recur?
    - A new hire checklist of all required education has been created

3. How does the program plan to monitor performance to ensure compliance?
    - A spread sheet has been created and will be monitored to endure all initial education is completed, and any re-education is noted with the date it is required by

4. The date by which the regulatory insufficiency will be corrected.
    - This regulatory insufficiency will be corrected by 2/17/2022

If you have any questions regarding this plan of correction, please feel free to contact me at 3139-338-8100.

Sincerely,

Tracy Sherzer, Executive Director

ok 2/9/22