Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number 10288			**Report date** **April 9, 2024**
Facility name Aspire of Perry		**Survey dates** **March 20, 2024 - March 27, 2024**	
Facility address 2625 Iowa Street			
City Perry	**JB**		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
58.28(3)e	**481—58.28(135C) Safety.** The licensee of a nursing facility shall be responsible for the provision and **maintenance of a safe environment for residents and personnel. (III)** **58.28(3)** *Resident safety.* *e.* Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) **DESCRIPTION** Based on clinical record review, staff interviews and facility policy review, the facility failed to ensure residents with impaired cognition couldn't exit the facility unattended for 1 of 1 resident reviewed for elopement (Resident # 1). The facility's front door alarm malfunctioned during the prior 30 days, despite the facility knowing about the malfunctioning alarm, the facility didn't get the alarm repaired. Due to the malfunctioning of the alarm, the facility staff didn't know a cognitively impaired resident left the building. Due to the proximity to the Highway 14, a major four lane highway (55+ miles per hour), this resulted in a likelihood of Resident #1 received a serious illness, injury, or death. When the door alarm malfunctioned, the facility staff had to disarm the alarm and re-engage the alarm, for the alarm to	Class I	**$5000.00** **Held in Suspension**	**Upon Receipt**

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Facility Administrator _____ Date _____

	function. The facility had at least 3 cognitively impaired residents who wandered the facility, with at least 2 residents without a wandering alert device, thus relying only on the front door alarm to notify staff if the resident left the building. This failure resulted in a likelihood of serious injury or death, therefore, causing an Immediate Jeopardy to the health, safety, and security of the residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of March 13th, 2024 on March 21st, 2024 at 12:00 PM. The Facility Staff removed the Immediate Jeopardy on March 21st, 2024 through the following actions: a. The facility implemented 24-hour continuous monitoring by a staff member of the door with the malfunctioning door alarm 3/21/24. b. The continuous monitoring will remain in effect until the door alarm is fixed. c. The facility completed an audit on 3/21/24 of all external facility doors to ensure no other doors malfunctioned. d. The facility contacted the Door Security Company on 3/21/24. e. The Door Security Company reported they would come to the facility on 3/22/24 to fix the door alarm. f. The facility educated all staff on 3/21/24 on the door alarm system. In addition, when they need to immediately notify the Administrator if someone knew of a malfunctioning door alarm. g. The Administrator or designee will audit door alarms daily to ensure functioning properly. The facility identified a census of 33 residents. Findings Include: Resident #1's Minimum Data Set (MDS) assessment dated 12/6/23 identified a Brief Interview for Mental Status (BIMS) score of 6, indicating severely			

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	impaired cognition. The MDS listed Resident #1 walked and transferred independently. The MDS included diagnoses of bipolar disorder (mood disorder), depression, and hypertension (increased blood pressure). The Care Plan reviewed 3/12/24 reflected Resident #1 transferred and ambulated independently without adaptive devices. The Health Status Note on 3/13/24 at 1:50 PM indicated the nurse noticed a certified nurse aide (CNA) walk toward the desk and notify the Director of Nursing (DON) that Resident #1 rang the doorbell, and a CNA let him in to the facility. Resident #1 reported he went to see what it's doing outside. Resident #1 wore a short sleeve red shirt and a red long sleeve shirt with sweatpants. The temperature outside measured 68 degrees Fahrenheit (F), but felt like 67 F. Resident #1 alert per self, knows the year, however could not tell the day of the week or month. Resident #1 walked per normal, no edema, no limp noted, skin warm and dry. Resident #1's assessment revealed a soft non-distended, non-tender abdomen with normal bowel sounds. He had no respiratory distress with even, nonlabored respirations. Resident #1 placed on hourly checks for forty-eight hours. The nurse notified the Administrator at 1:52 PM. At 2:45 PM the nurse received an order to apply a wandering alert device and check every shift received. The nurse applied the wandering alert device on his left ankle. At 2:49 PM Resident #1's family called and agreed with the plan of care, they didn't verbalize any concerns. The Health Status Note dated 3/13/24 at 2:48 PM indicated the event occurred at 2:48 PM and the nurse notified the Administrator at 2:52 PM, got the order for the wandering alert device at 3:52 PM and notified his family notified at 3:49 PM.			

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	The N Adv – Elopement Evaluation dated 3/13/24 at 8:34 PM reflected Resident #1 had an elopement score of 0. On 3/20/24 at 10:50 AM the Director of Nursing (DON) described Resident #1 as not a wanderer, and he needed to encouragement to leave his room. The staff reported seeing Resident #1 in the dining room at 2:45 PM. The DON explained they had everything in place for elopement risk. Such as, doing 15-minute visual checks and documenting them on the clipboard at the nurse's station. They applied a wandering alert device on Resident #1. The DON reported Staff F, CNA, discovered Resident #1 outside. The door alarm did not activate. Resident #1 did not have any injuries. Resident #1 exited through the front door. Resident #1 rang the doorbell and staff assisted him into the door. The front door is visible from the nurse's station. Resident #1's room is visible to the front door. According to statements DON obtained during the facility investigation, they determined Resident stayed outside for approximately 1-2 minutes. On 3/20/24 at 11:15 AM Staff H, Maintenance, reported the facility had 2 door alarm systems in place, a door alarm system and a wandering alert system The facility had the wandering alert system located on the patio, the employee entrance, and the front door. The facility tested the wandering alert system at least once a day when Staff H worked during the week, and didn't get tested on the weekend. He explained the facility always had the wandering alert system on. The facility had the wandering alert system in place before the incident on 3/13/24. The door alarm system didn't work on the front door that day, the system had an override malfunction. When opening or closing the front door, it would set off the alarm even after the code was entered in the key pad. Near the front door,			

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	the facility had a key pad to override the malfunctioning system, so staff put in a code at the front door to open the door, and if the alarm went off they went to the keypad at the nurse's station to disarm it or shut the alarm off. After shutting off the alarm, then they reentered the key code at the nurse's station to reactivate the front door alarm. On 3/20/24 at 12:10 PM Staff A, Social Services Director/Activities, reported the DON notified her of the incident. She assisted the DON and Administrator in getting statements, making sure Resident #1 was safe, and gathering information regarding the incident. Staff A added she knew how to alarm and disarm the door system, but didn't have to do it that day. Staff A explained when she started the door system had that malfunction, but she never saw anyone alarm or disarm the door that day. On 3/20/24 at 1:08 PM Staff H remarked the door malfunctioned for approximately a month or so. Staff H called a door company and they came to the facility on 3/18/24 to look at the alarm. The company reported they would email back with a date they could come fix it. Watched Staff H at the front door, put in the key code before opening the door, light turned green, Staff H opened the front door, and the alarm didn't sound. After he closed the door, the alarm sounded, Staff H went to the nurse's station, got a key from the key box and opened the override system lock box. He entered a key code to shut off the alarm, then entered the key code again to re alarm the front door. The override system displayed disarmed when he entered the code to disarm the alarm. When he re-alarmed it, the screen said alarmed, a red light for alarmed, and green light for disarmed. Staff H added all of the staff had access to the key at the nurse's station.			

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	On 3/20/24 at 11:46 AM Staff G, CNA, revealed she was at the nurse's station for shift change, she noticed Resident #1 went into the dining room. Staff G observed Resident #1 talking to a couple of the other residents in the living room, then she turned back around to the nurse's station. Staff G revealed a few moments later she heard the doorbell ring, and when she turned around, she observed Staff F, CNA, walking through the threshold with Resident #1. Staff F walked Resident #1 to his room and reported he got outside. Staff G explained she didn't know for sure how long the front door alarm malfunctioned that way. She didn't know for sure what happened with the alarm system, but everyone had the job to make sure the front door was alarmed. On 3/20/24 at 1:30 PM Staff B, Licensed Practical Nurse (LPN), said she didn't know if the door alarm sounded. Staff B added the front door didn't work correctly for only a short time. Staff B revealed all staff have access to alarm and disarm the front door, located at the nurses' station. Staff B reported the facility had residents who sat in the dining/living room area that would say if someone went towards the door. Staff B didn't see anyone alarm or disarm the door at the nurses' station that day. On 3/20/24 at 2:05 PM Staff E, CNA, explained at the time of the incident, he passed ice water down the east hallway, he briefly looked up and saw Resident #1 walk to the dining room. He heard the doorbell ring and didn't remember hearing the door alarm go off. Staff E revealed he knew how to reset the door alarm and that all staff should check to make sure the door was alarmed. Staff E revealed that Resident #1 didn't usually wander out of his room. Staff E revealed he heard the doorbell ring and came out of a resident's room but didn't know			

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	if anyone got outside and didn't see who answered it. On 3/20/24 at 3:30 PM the Administrator revealed he went to the grocery store to get Gatorade for another resident. When he looked at his watch, it said 2:47 PM, he said as he approached the street, he looked at the building and didn't see anyone outside. The Administrator explained he received a message to get to the facility right away, as Resident #1 got outside. When he returned to the facility, he started the investigation. The Administrator added Resident #1 didn't get close to the front door, he sat at the first table in the dining room if he came out of his room. He stated Staff F found him outside. The Administrator reported the day after the incident, the facility completed an elopement drill and Resident #1 didn't want to participate or get close to the front door. The Administrator reported with encouragement Resident #1 could open the front door during the drill. The Administrator said Staff H completed door checks every morning and the door has been malfunctioning the last couple weeks. The facility report named Logbook Documentation Doors lacked documentation, indicating the facility didn't check the door alarms on 2/15/24, 2/18/24, 2/24/24, 2/25/24, 2/27/24, 3/3/24, 3/8/24, 3/10/24, 3/16/24 and 3/17/24. On 3/20/24 at 4:20 PM the DON revealed the facility didn't have cameras. Resident #1 didn't have visitors and never did. In addition, the facility didn't have anything outside to catch his attention. The DON denied hearing the doorbell or the door alarm. Re-interview on 3/20/24 at 4:33 PM Staff G reported Resident #1 didn't have visitors, nothing outside to catch his attention, he had a shed he could see through his window with people going in			

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	and out of it. Staff G revealed she didn't hear the door alarm, but did hear the doorbell. When the doorbell sounded, Staff F stood next to her and then Staff F left the area. Staff G assumed Staff F answered the doorbell, but she didn't see Resident #1 outside until Staff F and him crossed the threshold to the dining room. Re-interview on 3/21/24 at 9:30 AM Staff B explained the facility had a stop sign in place before the incident on 3/13/24. All of the facility's exit doors had stop signs in place. On 3/21/24 at 2:30 PM Staff F, CNA, reported she came to work at 2:00 PM, noticed the front door alarm not alarmed, so she went and alarmed the door. Staff F revealed she knew it wasn't alarmed by the override system at the nurse's station. Staff F revealed that around 2:45 to 3:00 PM the doorbell rang and she went to answer it. As she answered it she saw Resident #1 outside. Staff F, let Resident #1 in, and looked around to see if he was alone. Staff F revealed Resident #1 said he went outside to get fresh air and she asked how he got out here, he said he went through the front door. Staff F revealed the stop sign was not up when she went to answer the door. Staff F revealed she took Resident #1 up to the front desk to let the DON and Staff B, LPN, know. Staff F stated Resident #1 never attempted to leave the building, that he barely left his room. Staff F thought maybe because it was nice out Resident #1 wanted to get out. Staff F said Resident #1 didn't have any injuries, no visitors, and no physician appointment, nothing out of the ordinary that day for him, Staff F stated when she heard the doorbell rang she was coming out of the east hallway, and didn't hear the door alarm before the doorbell. Staff F described the previous door alarm as loud and that it finally went out. Staff F added the new one didn't sound loud enough and needed to be replaced, when asked if she alarmed the door			

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	at 2 PM when she came on shift and she didn't hear the door alarm when Resident #1 went outside, she said she felt someone disarmed the door in between the time she alarmed it and when Resident #1 went outside. The Elopement Management Policy dated 2023 directed clinical processes that address a resident's risk of elopement from the premises or a safe area without authorization and/or necessary supervision to do so. a. Identification and implementation of individualized approaches to provide the resident with a safe and secure environment. b. Evaluation of the resident's individualized plan of care and validation of effectiveness of interventions c. Based on the resident's evaluation, the interdisciplinary Team develops an individualized care plan to prevent elopement. This will include interventions specific to the risk factors identified. If the facility uses a Wandering alert device or like system, then the Environmental Services Director/designee checks the functionality of that system daily. Environmental Services also checks the security system on a monthly basis through the TELS system. d. The Environmental Services Director/designee tests and documents that exit doors are secured and that alarms or electronic keypad locks function as designed. Interview with the Administrator on 3/21/24 revealed they did not start documenting the communication between the door company and the facility regarding the repair of the malfunctioning front door alarm. The first communication documented listed a date of 3/13/24, the day of the incident. **FACILITY RESPONSE**			

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