STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165423	A. BUILDING _____ B. WING _____	C 06/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF AMES, LLC	3440 GRAND AVENUE AMES, IA 50010

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 7-15-16 The following information is related to the investigation of facility reported incident #60323-I, which was substantiated.	F 000	**Preparation and/or execution of this plan of correction does not constitute admission or agreement by Accura Healthcare of Ames of the facts alleged, or conclusions set forth in this statement of deficiencies. Accura Healthcare of Ames maintains that these alleged deficiencies do not individually or collectively jeopardize the health and/or safety of its residents, nor are they of such character so as to limit this nursing facility's capacity to render quality care.**	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interview, the facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 1 of 5 residents reviewed (Resident #5). Facility census was fifty (50) residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment tool dated 5/20/16, Resident #5 had diagnoses that included dementia and blindness in both eyes. The MDS revealed the resident displayed severe cognitive impairment, severely impaired vision and moderate hearing	F 309	F309 7/15/16 1. Resident #5 had an incident report, skin condition report completed and nurses notes updated c/o bruise on 6/15/16. The hoyer lift hooks were padded on 6/15/16. No other transfer injuries were identified. 2. All residents requiring a hoyer lift for transfers will follow our safe resident transfer techniques policy. 3. A safe lift transfer in-service was conducted by our workers comp representative on 6/24/16, that included safe resident transfer techniques. The Director of Nursing educated staff J, RN on 7/11/16, pertaining to timely completion of incident reports, skin condition report and documenting in the nurses notes	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Administrator 7/15/16

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F 309	Continued From page 1 impairment. The MDS also revealed Resident 35 required total assistance of two staff with bed mobility, transfers, and toilet use, and did not ambulate (walk). Observation showed, on 6/15/16 at 10:55 a.m. the resident in a wheelchair in the hallway. The resident had a 50 cent sized bruise to the left side of the forehead with some swelling around the area that extended to the left eye. The resident stated he/she received the bruise from the grab bar on the lift. The resident stated he/she couldn't do anything about it - he/she "just has to take it". The resident stated he/she wished staff would be more careful. The surveyor then tested the resident's cognitive ability. The resident didn't know the month or year but knew he/she was in Iowa. The resident stated he/she didn't know the President's name because he/she was blind and couldn't read. A review of the resident's nurses notes revealed they failed to contain information about the resident's left forehead bruise. On 6/15/16 at 12:15 p.m. Staff J RN stated she saw the forehead bruise yesterday, but did not document it. She didn't know if paperwork was completed and in someone's office, and then she had an appointment and had to leave. A skin condition report dated 6/15/16 identified a left side of forehead bruise measuring 3.5 centimeters (cm.) by 2.4 cm. gray bruise with yellow edges. A quality assurance (QA) monitoring tool dated 6/15/16 identified a mid forehead bruise light purple in color measuring 5 cm. by 2.4 cm.	F 309	upon observation of any skin issues. Random shower sheets audits will be completed by the Director of Nursing on a weekly basis for 3 months. 4. Random shower sheets will be reviewed by the DON on a weekly basis to validate any skin irregularities, if so, an incident report will be completed. All late incident reports will be brought to the quarterly QAPI for review by the IDT to determine cause and if further interventions will be required.	

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F 309	Continued From page 2 etiology unknown. The report indicated the resident didn't know how it occurred when asked. The intervention following the incident was "pad Hoyer hooks". Observation showed on 6/15/16 at 11:40 a.m. two staff transfer the resident from the wheelchair to bed for care. After staff provided care, they transferred the resident back into the wheelchair. Observation showed the center pole and lift bars of the lift padded. During the transfers, these areas of the lift did not come in close contact to the resident's face.	F 309		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure residents environment remained as free of accidental hazards as possible and each resident received adequate supervision to prevent accidents for 2 of 4 residents (Resident #1 and Resident #4). Resident #1 left the facility without staff knowledge and a visitor brought him/her back inside. Resident #1's wanderguard alarm did not function; and staff turned off the door alarm system without checking to ensure who caused	F 323	F 323 1. Resident #1 was brought back into the facility. The charge nurse completed a full body assessment with vitals on 5/27/16, no injuries were observed. The Wanderguard wrist transponder was tested and was operable. Although the wrist transponder was operable, the administrative nurse changed out this resident's transponder again on 5/27/16. The resident was immediately placed on 1 hour checks until 5/31/16. 1. Resident #4 was sent out to the local emergency room on 5/30/16. The ER took x-rays that determined the chronic osteoporosis likely contributed to the fracture. Resident was admitted back to the facility on 5/31/16 with no surgical interventions done. On 6/1/19, a reclining back wheelchair was provided for comfort and safety. The care plan was updated.	6/21/16

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F 323	Continued From page 3 the alarm to sound. The findings constituted an immediate jeopardy to residents' health and safety. Resident #4 fell in the dining room and all 3 nursing staff were in a resident's room with the door shut and 2 of the staff stated they did not hear Resident #4's pressure alarm. A nearby dietary staff heard Resident #4's alarm but did not immediately respond thinking someone else would get it. Resident #4 had been found about 6 feet from his/her wheelchair and sustained a hip fracture. The facility identified a census of fifty (50) residents. Findings include: 1. A Minimum Data Set (MDS) with assessment reference date of 5/5/16, assessed Resident #1 with a brief interview for mental status (BIMS) score of "3" (severe cognitive impairment). The MDS identified the resident with an acute change in mental status. The resident had a behavior problem of rejection of care. The MDS did not identify a concern with wandering. The resident transferred and ambulated independently. A "balance during transitions and walking" test revealed the resident as not steady but able to stabilize with staff assistance. The resident used a walker with ambulation. The resident had diagnoses that included: dementia and history of falling. The resident had one fall without injury since the prior assessment. An elopement risk assessment dated 5/11/16 identified the resident with a score of "11". Five (5) or more points revealed the resident at risk for elopement. The risk assessment revealed the resident could not recognize safety risks and had impaired decision making skills. The resident had	F 323	2. All residents will be assessed (on admit and quarterly) for elopement risk. If assessed an elopement risk, the resident will be issued a wanderguard wrist transponder, a picture taken and placed in the elopement books at both nurses station. Resident care plans will be updated to include wanderguard use, and elopement risks with interventions. Certified Nurse Aides will have their walking care plans updated with any resident who is issued a wanderguard. All sounding alarms will be acknowledged and responded to by any/all staff per policy. 2. All residents with sounding personal alarms will be responded to promptly by any and all staff. Personal alarms will be documented on the treatment sheets and care plans by the charge nurse. The nurse aide walking care plans will be updated for personal alarm use by the administrative nurse. The nurse will check for placement and efficacy each shift. 3. A technician up-dated the audible on the wanderguard and front door alarms with louder decibel speakers on 6/15/16. All staff were educated regarding the Walk Away/Missing Resident Policy and personal alarms by the Administrator and Director of Nursing on 5/30/16, 6/10/16 and 6/15/16.	

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F 323	Continued From page 4 a history of elopement attempts and the resident had a current behavior of wandering with the ability to open a door. A care plan dated 5/4/16 revealed the resident had alteration in thought processes/cognitive with BIMS score of 3 and senile dementia. The care plan revealed the resident used a wanderguard (a device to alert staff if the resident left the building without staffs knowledge) for elopement risk. An addendum dated 5/27/16 revealed the resident exited the building unattended. Staff replaced the wanderguard on the left wrist and placed a wanderguard on the walker. On 6/9/16 staff removed the wanderguard on the walker due to potential interference issues. The care plan also identified the resident at risk for falls. Nurses notes, dated 5/27/16 at 8:50 p.m. and written by Staff A LPN (licensed practical nurse) revealed at around 1:30 p.m. the resident walked into the building from the parking lot by a family member of another resident. When asked what he/she did outside, the resident stated he/she couldn't find their way home. Assessment showed no injury. Observation revealed the resident's wanderguard in place but the wanderguard did not activate when the resident left the facility. Staff placed the resident on hourly checks until maintenance repaired the wanderguard concern. An elopement investigative report dated 5/27/16 revealed the Director of Nursing viewed the resident approximately between 1:15 p.m. and 1:30 p.m. sitting by the front door. The resident exited from the front door. A family member of another resident brought the resident back in the facility at 1:30 p.m. The weather was sunny,	F 323	All new staff will receive training during their orientation by the Business Office Manager, pertaining to the Walk Away/Missing Resident Policy with an attestation placed in their file. All current staff will receive elopement/alarm training, Walk Away/Missing Resident Policy twice a year by the Administrator and/or Director of Nursing. Elopement drills will be completed x 3 weeks and quarterly thereafter by the Administrator and/or Director of Nursing. The Certified Nurse Aide who shut the alarm off received a written final disciplinary action on 5/27/16 for turning off the door alarm without following the Walk Away/Missing Resident protocol. Door alarms are checked daily by the Maintenance Director and weekend assigned staff. The charge nurse will check personal alarms each shift for placement and function. 4. Door audits and elopement drills will be reviewed at the quarterly QAPI with the Interdisciplinary Team members (IDT) to determine cause and if further interventions are required.	

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F 323	Continued From page 5 temperature in the 70's with a breeze blowing. The resident had been dressed in shoes, socks, slacks and a shirt. Staff checked the door alarms after the incident and the door and the alarms all functioned. An elopement investigative procedure dated 5/31/16 revealed that when the incident occurred, the door alarm functioned and a CNA (certified nurse aide) turned the alarm off without checking to see if a resident went outside. Visitor that discovered resident outside: On 6/13/16 at 2:19 p.m. the visitor stated she was coming to the facility to assist with a birthday party at 1:30 p.m. She observed the resident outside with a walker. The resident was across the parking lot and just about to the grass in front of Grand Avenue. The resident stated he/she tried to find their way home. Prior to returning back into the facility, the resident requested to sit on the bench in front of the facility. They sat there for a minute and came back in. Staff B, CNA was at the desk when they came back into the facility and looked shocked that Resident #1 had been outside. Staff B was the only one that saw her bring the resident inside. The visitor stated no alarm sounded when they came back in. She pushed the door alarm button so that would not sound but she did not hear any other alarm (wanderguard). She stated she found out a CNA left at noon and maybe no one filled on for the staff that left and they were short staffed. Staff working when the incident occurred: On 6/13/16 at 11:50 a.m. Staff B CNA stated there was a lot of visitors coming and going the day of the incident. The other CNA left at 12:30 p.m. so she and Staff E LPN (licensed practical	F 323		

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F 323	Continued From page 6 nurse) had to lay everyone down. They were in a room with a resident that was screaming and wanting up for the birthday party. They had the room door shut while providing care to the screaming resident. As soon as Staff B opened the room door she heard the door alarm sounding. Staff B did not hear the alarm in the room. Family and visitors were going in and out all day long and the wanderguard did not sound so Staff B just assumed it was staff/family and shut it off. She stated normally the nurse stays at the nurses station, but that day the nurse had to help with cares because they were short staffed. After that, they laid more residents down. Staff B did not think any resident left because the wanderguard did not sound. Staff B sat down to do books and saw Resident #1 come in with a visitor who said she saw the resident outside. Staff B stated the wanderguard did not sound when the resident came back in the facility. She stated 2 weekends ago (after Resident #1's incident) the wanderguard did not sound when Resident #2 followed Staff C CNA out. Staff B stated she had training on responding to the door alarm after the incident but not before the incident. Staff B received an employee disciplinary report and signed it 6/2/16. The report revealed Staff B shut off the door alarm without checking to see if any residents went outside and that was a "huge safety violation". The disciplinary report stated anytime any alarm sounds staff is to immediately check it to assure the safety of residents. Staff B documented on the report in the employee comment section. Staff B wrote they were short staffed and she was with another resident doing cares. That resident was screaming because	F 323		

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F 323	Continued From page 7 Staff B left so she returned to the resident. The wanderguard did not go off and family came in and out all day so Staff B assumed it was family because no other alarm went off. All the residents up front were either in bed or in the living room so she kept providing cares because she was the only CNA up front. On 6/14/16 at 2:07 p.m. Staff B stated the panel on the alarm panel box indicated the door alarm sounding was from the front door. After she saw the visitor bring the resident back into the facility she said she did not tell anyone and then someone came and asked her about it. On 6/14/16 at 10 a.m. Staff H CMA/medical records stated there was no CNA orientation checklist for Staff B to show he/she was educated on door alarm response. Review of facility in-service records showed the facility reviewed the alarm/elopement policy 3/10/16 and Staff B attended. On 6/14/16 at 12:36 p.m. Staff A LPN stated she came to work at 2 p.m. on the day of the incident. The resident was already back inside. She stated she was informed that the wanderguard did not sound. She stated Staff D LPN was also told the wanderguard did not sound. Staff A stated if staff is in a room with a door shut halfway to the end of the hall, staff can ' t hear the alarm. On 6/13/16 at 12:35 p.m. Staff E LPN stated she worked with Staff B on the day of the incident. She stated she did not know the resident left until she heard someone talking about it. The resident was already back inside then. Staff E stated the resident lives on the back of the facility but comes	F 323		

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F 323	Continued From page 8 to the front wing every day to watch the television. She stated she didn't even know who the resident was or that the resident wore a wanderguard. She stated it would have been nice to know the resident was a flight risk. She was in a resident room with Staff B when she heard an alarm. Staff E held the resident as Staff B cleaned the resident. When the alarm sounded, Staff B went and checked and then came back. Staff B said it was the door but didn't say who it was. It was a busy day and no one was pushing the button. Staff E guessed that Staff B thought it was a visitor. On 6/14/16 at 10:05 a.m. Staff D LPN stated she was the resident's nurse the day of the incident. The resident spends most of the day in the front sitting in the television lounge area. She checked the resident's wanderguard that morning and it worked. She stated she didn't hear the alarm that day or turn it off. She stated the resident was his/her usual self that day. She stated maintenance stated the wanderguard range was low so they increased the range. On 6/13/16 at 3:04 p.m. Staff F CNA stated she was in the shower room when the incident occurred. She heard about it later. She stated she didn't hear the alarm or turn it off. On 6/14/16 at 12:42 p.m. Staff F stated when in rooms toward the end of the hall with door shut then she can ' t hear the alarms. On 6/13/16 at 12:50 p.m. Staff G CNA stated she didn't remember hearing any alarms that day. On 6/13/16 at 11:38 a.m. Staff H CMA (certified medication aide) stated she heard the resident got out. They didn't know what happened with the	F 323		

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F 323	Continued From page 9 wanderguard so they cut the wanderguard bracelet off the resident after the incident and took it to the door and the alarm sounded. She applied a new bracelet to the resident's wrist. Staff previously applied a new bracelet 2 days before the elopement incident. Staff H stated she did not hear the alarm. The resident was already back inside when she heard about the incident around 2:15 p.m. to 2:30 p.m. She did not know when the resident left. She stated staff did not know why the wanderguard did not sound. Staff H stated she did not know if staff could hear alarms when in rooms. On 6/13/16 at 3:10 p.m. the Director of Nursing (DON) stated she did not hear the alarms. She stated there was a lot of commotion that day. She was in her office in the C-hall. The first she knew if the resident leaving was when the resident and family walked down the hall a little after 2 p.m. Awhile later a lady (visitor) told the activity director she saw the resident in the parking lot. The resident was heading out and she went up to the resident. The DON stated the visitor waited 30 minutes before telling a staff about the incident. The DON stated they checked the wanderguard and it worked on the door. She saw the resident around 1:15 p.m. to 1:30 p.m. sitting by the front door. The resident stated he/she was looking for his/her way home when outside. The DON stated they asked staff if anyone turned the wanderguard off and could not find anyone saying they shut it off. The DON denied any issues with the wanderguard before the incident. On 6/13/16 at 1:25 p.m. the MDS/care plan nurse stated she heard about the incident after it occurred. She worked in her office in C-hall and didn't recall if she heard any alarms. With the	F 323		

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F 323	Continued From page 10 birthday party that day, she may not have heard it. If she hears an alarm she will go check. She stated she didn't turn off any alarms that day. She was not aware of the resident trying to leave before 5/27/16. She denied any concerns with the wanderguard not working. On 6/13/16 at 1:38 p.m. the nurse manager stated she was informed by Staff I (registered nurse) 2 p.m. to 10 p.m. nurse that the resident exited the building. She stated she didn't hear any alarms and didn't turn any off. She stated if staff is working in the back that they can ' t hear the alarms in the front. The resident never tried to leave before. He/she would stand in the doorway but never tried to leave. She stated if maintenance was not at the facility to check the door alarms that staff needed to check them. She stated after the incident they placed a wanderguard on the resident's walker as well as his/her left wrist. The wanderguard/alarm repair person said not to use one on the walker since it may interfere with the wanderguard on the wrist so they removed it from the walker. Other staff: On 6/14/16 at 9:27 a.m. Staff J (registered nurse) stated there had been problems with the wanderguard alarm not always activating. Anytime this occurred staff notified maintenance and maintenance would check the wanderguard. On 6/14/16 at 12:12 p.m. Staff C CNA stated Resident #2 followed him/her out and the wanderguard did not activate. She identified Staff I (registered nurse) as a witness to the incident and after that maintenance checked it.	F 323		

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(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) COMPLETION DATE
F 323	Continued From page 11 On 6/14/16 at 2:30 p.m. Staff I (registered nurse) confirmed that Staff C went out the front door followed by Resident #2 (who wore a wanderguard). The wanderguard did not sound so she called the maintenance person who came out and worked on the wanderguard. On 6/14/16 at 12:25 p.m. Staff K CNA stated the wanderguard did not work right for a couple weeks. It either didn't sound or it sounded when no one was around. On 6/13/16 at 12:12 p.m. the maintenance person denied there had been any problems with the wanderguard prior to the incident. He stated he didn't know why the wanderguard didn't sound on 5/27/16. He stated the wanderguard/alarm person moved the wanderguard box to the door frame. It was further away before it was moved. The sensitivity was increased and now should activate when a resident gets within 3.5 feet of it. He stated he was not here the day the incident occurred. He was on vacation that day until 6/1/16. Wanderguard/alarm repair person: On 6/13/16 at 2:02 p.m. the wanderguard/door alarm repair person stated the wanderguard activated when a resident wearing the wanderguard got right to the door so he increased the sensitivity. When asked why the wanderguard didn't sound when the resident exited on 5/27/16, he stated the system was old so interference was an issue. When the system was developed years ago we didn't have all the electronic things we have now. Someone may have had something electronic on them as the resident went through the door causing the	F 323		

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F 323	Continued From page 12 wanderguard not to sound. It is unknown what may have interfered with it. The system was prone to interference. Prior to the 5/27/16 incident, no one told him there were issues with the wanderguard. On 6/14/16 at 12:03 p.m., the DON stated she checked the doors during the maintenance person's vacation except for 5/29/16. She stated she did not check the doors 6/4/16, 6/5/16, 6/11/16 or 6/12/16. The facility identified 3 residents wore wanderguards. Observations: Observation showed, on 6/13/16 at 10:45 a.m. the wanderguard alarm activated when Staff H CMA walked with Resident #1 to the front door. The resident walked with a walker and wore a wanderguard on the left wrist. On the same date at 1:40 p.m. the resident sat in the front television lounge area and denied walking out of the facility into the parking lot. On 6/13/16 at 11:15 a.m. all doors contained 2 alarms. All wanderguards and door alarms activated appropriately when checked by the surveyor and Staff H. On 6/14/16 at 12:25 p.m. the surveyor went in the room that staff were in when the incident occurred on 5/27/16 with the door shut (to test the alarms.) The surveyor could not hear the wanderguard or door alarm. Staff K CNA was in the room with the surveyor and stated she did not hear them either.	F 323		

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F 323	Continued From page 13 On 6/15/16 Staff H and the surveyor measured the distance from the front entrance of the facility to the grassy area between the parking lot and Grand Avenue. The distance measured 84 feet. A missing resident drill conducted on 6/8/16 at 4:15 p.m. revealed the front door alarm sounded and the DON responded. The DON documented that the nurse was in A hall with a resident and the room door shut and the CNAs were in B hall with the door shut. On 6/14/16 at 1:07 p.m. the surveyor asked the DON about documenting staff were in rooms with doors shut. Did she document "doors shut" because they didn ' t hear the alarm sound in the rooms or did she mean they were too busy to answer the door alarm? The DON stated she thought they were busy in rooms. She didn ' t recall if she asked staff why they didn ' t respond. The DON stated she wasn ' t sure if staff could hear alarms in rooms with air conditioning running and the doors shut. She stated she could hear the door alarm in her office with the air conditioning running but she keeps her office door open. Wanderguard/alarm person: On 6/15/16 at 9:15 a.m. the wanderguard/alarm person stated he was putting in a louder speaker for door alarm. He stated the prior speaker was not part of the original door panel box system. Someone had glued a personal alarm speaker in the alarm panel box and when he opened up the alarm box he discovered the speaker at the bottom of the alarm panel box so it was not a functional alarm speaker. Following installation of the new speaker in the alarm box on 6/15/16, the surveyor went to the	F 323		

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F 323	Continued From page 14 same room where staff worked when the 5/27/16 incident occurred to test the audibility of the alarms. The new alarm speaker was clearly audible. Administrator timeline: The Administrator gave the surveyor a timeline on the morning of 6/14/16. She documented the facility checked the wanderguard door alarms weekly until 6/1/16 and then they started checking them daily. The facility went back to weekly checks 6/7/16 due to wanderguard and new keypad updates. Resident #1 was on hourly checks until 5/31/16 when the facility got a keypad on the front door. On 6/7/16 the wanderguard/alarm person moved the wanderguard at the front entrance and applied a new door alarm keypad and increased sensitivity of wanderguard sensors. The nurses checked bracelets for placement and function every shift. That was in place before the incident and after. Policy: The facility walk away/missing resident policy revealed the following: If a door alarm sounds, identify the door that caused the alarm to activate. Proceed to that door and attempt to verify the cause of the alarm activation. Should staff be unable to determine the cause of the alarm activation, all known potential elopement risk residents should be accounted for. If all are accounted for, a further accountability of all residents is warranted. If an elopement risk resident cannot be accounted for, a systematic search of the facility premises and grounds should be initiated under the instruction of the charge nurse.	F 323		

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F 323	Continued From page 15 On 6/14/16 at 11:55 a.m. the Administrator gave the surveyor a list of staff that identified which staff had or had not been in-serviced regarding alarm response. The surveyor asked about weekend staff and other staff that had not been in-serviced. The Administrator stated that is why she planned weekly in-services for a month. By the end of the month, everyone should have received the in-service training. On 6/14/16 at 12:25 p.m. the Administrator stated 14 of 51 staff listed had not been in-serviced yet. The elopement occurred on 5/27/16 and staff placed the resident on hourly checks until maintenance repaired the wanderguard concern and the resident received a new wanderguard bracelet. On 5/31/16, the facility in-serviced some staff with instructions to not turn off the door alarm until they are sure residents did not leave. The Administrator reported the following timeline: Resident #1 was on hourly checks until 5/31/16 when the facility got a keypad on the front door. The facility checked the wanderguard door alarms weekly until 6/1/16 and then they started checking them daily. The facility went back to weekly checks 6/7/16 due to wanderguard and new keypad updates. On 6/7/16 the wanderguard/alarm person moved the wanderguard at the front entrance and applied a new door alarm keypad and increased sensitivity of wanderguard sensors. The nurses checked bracelets for placement and function every shift. That was in place before the incident and after. On 6/8/16, the facility completed missing resident drill/s for some staff.	F 323		

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F 323	Continued From page 16 The facility abated the IJ on 6/14/16 when they completed education to all staff on wanderguard and door alarm procedure/elopement to go outside and determine if a resident triggered the alarm before turning the alarm off. Also staff were educated to tell the nurse to complete a head count of residents. These actions lowered the IJ from J severity to D severity with the need of ongoing monitoring to ensure residents received adequate supervision. 2. A MDS with assessment reference date of 4/21/16 assessed Resident #4 with a BIMS score of "3" (severe cognitive impairment). The resident required extensive staff assistance with bed mobility, transfers and toileting. The resident required limited staff assistance with ambulation. a "balance during transitions and walking" test revealed a score of "2" in all areas of testing. A score of "2" revealed the resident was not steady and only able to stabilize with staff assistance. The resident used a walker for ambulation. The resident had diagnoses that included: stroke and unspecified abnormalities of gait and mobility. The MDS did not identify previous falls. A care plan dated 4/20/16 revealed the resident at risk for falls related to impaired mobility and history of cerebrovascular accident (stroke). The care plan identified on 4/4/16 the resident self-transferred and laid self in the floor in the dining room. Staff initiated a pressure alarm at all times after that incident. An addendum dated 5/30/16 identified another incident. The resident self-transferred and fell in the dining room. The resident went to the emergency room (ER). Nurses notes dated 5/30/16 at 2:15 p.m. and	F 323		

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F 323	Continued From page 17 documented by Staff E LPN revealed at approximately 7:55 a.m. Staff E heard residents in the dining room yell at someone and then they began to yell "nurse she fell!" Staff E went to the dining room and observed the resident lying on his/her left side on the floor of the dining room yelling loudly that his/her right leg hurt. Staff E phoned the DON, ARNP (advanced registered nurse practitioner) and the resident's family. In addition to a leg injury, observation revealed a contusion to the right eyebrow and the resident's eyeglasses appeared bent. The resident transported to the Emergency Room at 8:30 a.m. Nurses notes dated 5/31/16 at 4 p.m. revealed the resident returned to the facility with a diagnosis of right hip fracture and urinary tract infection. The hospital history and physical (H & P) dated 5/30/16 revealed the resident was in the dining room in a wheelchair and attempted to get out of the wheelchair and suffered a fall. The fall was not witnessed. Staff found the resident on the floor and the right leg appeared shortened. The resident transported to the hospital and x-rays revealed a closed intertrochanteric comminuted hip fracture. The H & P also identified a CT (computerized tomography) of the head and neck showed no acute abnormalities. The H & P revealed the resident would transport back to the nursing home at family request. The family elected to treat without surgery due to the resident's advanced dementia and chronic non-ambulatory state. An ED (emergency department) note identified the resident had an unwitnessed mechanical fall at the nursing home with a right hip fracture. The note identified the resident with diagnoses of chronic osteoporosis which likely contributed to the fracture.	F 323		

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F 323	Continued From page 18 On 6/15/16 at 9:18 a.m. Staff E LPN stated all 3 front nursing staff were in the same room with the door shut when the resident fell and no one in the room heard the alarm. When they opened the room door Staff E heard everyone saying the resident was on the floor. She stated she ran to the resident who was screaming saying he/she had a broken leg. Staff E stated no staff was with the resident when she arrived. On 6/19/16 at 3:31 p.m. Staff B CNA stated all 3 front nursing staff were in a resident room with the door shut and didn't hear the resident's alarm. Staff B stated they didn't know anyone fell or an alarm was sounding until someone from dietary knocked on the door and said someone fell. When they came out of the room, they could hear the alarm. Staff B stated it was Memorial Day and they were short staffed. She identified Staff F CNA as in the room. She said Staff F is a shower aide but that day had to work as a regular CNA because they were short staffed. On 6/15/16 at 10:07 a.m. Staff L (dietary) stated she heard the alarm in the kitchen for 1 to 2 minutes before she went to investigate. She stated she waited because she thought other staff would respond to the alarm. She stated she was the first one to arrive and the resident was on the floor. She waited for a nurse aide to show up. After about 30 seconds the dietary manager arrived and right after that Staff B showed up. Staff L stated she was told to let nursing handle alarms unless it rings for an extended time. On 6/15/16 at 9:52 a.m. the dietary manager stated she heard the alarm for a little while when she was in the back unit. She heard it and waited	F 323		

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F 323	Continued From page 19 about 45 seconds to a minute and it still sounded so she went to check. She stated she thought the front unit staff would get it. When she arrived to the front, she observed the resident on the floor and Staff L kneeling by the resident. Staff B and Staff E then came out of a room. The dietary manager stated the resident's wheelchair still had the foot pedals down and the resident was about 6 feet away from the wheelchair. On 6/29/16 at 9:55 a.m. Staff F CNA stated she was supposed to give showers that day but there was no one there to work with Staff B so she could not give the scheduled showers. She stated she heard the alarm sound in the room and went to it right away. When questioned that the other 2 staff stated no one heard the alarm and no one reported seeing Staff F by the resident after the fall, she stated she either heard Resident #4's alarm or Resident #3 because Resident #3 also activated his/her alarm. Observations: On 6/15/16 at 1:10 p.m. observation showed 2 staff transfer the resident to bed. The resident complained of the right leg "hurting badly". On the same date at 1:18 p.m. the surveyor went in room A10 (where staff was when Resident #4's incident occurred) and shut the door. The surveyor did faintly hear the personal alarm sound from the dining area by the piano (where Staff E stated the resident fell). When the surveyor exited room A10, Staff E was outside the door and said the test the surveyor just conducted was not totally accurate because there were 3 staff in room A10 all talking and working with the 2 residents in the room when the incident occurred.	F 323		

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F 323	Continued From page 20 On 6/15/16 at 12:42 p.m. the Administrator stated all staff received training and instruction to respond to personal alarms right away. She stated she knew the dietary manager said she heard the alarm 45 seconds to 1 minute and they responded quickly. She stated the dietary manager spoke with Staff L (dietary) about responding to alarms. On 5/31/16 the facility trained all staff to respond to alarms.	F 323		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete performance evaluations at least every 12 months for 5 of 5 staff reviewed and staff failed to attend the required 12 hours of in-service per year for five of	F 497	F497 1. Staff M had an annual evaluation on 7/11/16. Staff N had an annual evaluation on 7/11/16 Staff O had an annual evaluation on 7/11/16 Staff P had an annual evaluation on 7/11/16 Staff Q had an annual evaluation on 7/11/16 1. Staff M is current with 2016 in-services. Staff N is current with 2016 in-services Staff O is current with 2016 in-services Staff P is current with 2016 in-services Staff Q is current with 2016 in-services 2. All Certified Nurse Aides (CNA) will attend our mandatory in-services and training each month as a requirement of employment. In-services must be made up by the end of the month in which they are held. Failure to make up an in-service will result in disciplinary action. All CNA's will receive an annual performance evaluation on or near their annual hire date.	7/15/16

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F 497	Continued From page 21 five staff reviewed. Facility census was fifty (50) residents. Findings include: 1. The facility identified Staff M CNA (certified nurse aide) as hired as 2/6/14. The facility had no performance evaluation on file for Staff M. Review of 2015 inservices revealed Staff M had 5 hours of inservice for the year. 2. The facility identified Staff N CNA as hired 12/27/12. The facility had no performance evaluation on file for Staff N. Review of 2015 inservices revealed Staff N attended 6 hours of inservice for the year. 3. The facility identified Staff O CNA as hired 6/26/14. The facility had no performance evaluation on file for Staff O. Review of 2015 inservices revealed Staff O attended 1 hour of inservice for the year. 4. The facility identified Staff P CNA as hired 9/10/14. The facility had no performance evaluation on file for Staff P. Review of 2015 inservices revealed Staff P attended 1 hour of inservice for the year. 5. The facility identified Staff Q CNA as hired 11/19/01. The facility had no performance evaluation on file for Staff Q. Review of 2015 inservices revealed Staff Q attended 2 hours of inservice for the year. 6. Review of inservices for 2015 identified the facility offered 10 hours of inservice. On 6/15/16 at 11:30 a.m. Staff H (medical records) and the MDS/care plan nurse revealed each monthly	F 497	3. An in-service was conducted by the DON on 7/11/16 pertaining to attending mandatory in-services, annual evaluations, door alarms, wanderguard alarms and survey deficiencies. 4. The Business Office Manager will review monthly in-services to audit who attended and who will require to make-up the time and training each month. The DON will review attendance at in-services for disciplinary actions. In-service audits will be brought to the quarterly QAPI for review by the IDT to determine cause and if further interventions are needed.	