Department of Inspections and Appeals
Health Facilities Division
Citation

Number **FC 6208**			**Report date** **July 21, 2016**
Facility name **Eldora Specialty Care**		**Survey dates** **July 5-7, 2016**	
Facility address **1510 22nd Street**			
City **Eldora IA. 50627**	**HL**		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
58.28(3)e	**481- 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 observation, record review and interviews, the facility failed to ensure Resident #1 received adequate supervision to protect against hazards in the environment. Resident #1 left the dementia unit through a window without staff's knowledge and a community member observed him/her 3 blocks away from the nursing home. Staff acknowledged knowing Resident #1 had eloped from a window at a prior nursing home. Staff reported Resident #1's 15 minutes checks had not been completed at the time of the elopement as result of only one staff in the dementia unit who had been providing cares to another resident. The facility reported a census of 9 residents in the dementia unit and a total census of 30 residents. Findings include: 1. According to the MDS (Minimum Data Set) dated 4/14/2016, Resident #1 had severe impairment of cognitive skills for daily decision making, transferred and ambulated independently and had diagnoses including hypertension, vascular dementia and heart failure. The Elopement Risk Assessment completed on 4/14/2016 documented Resident #1 had a high elopement risk. The assessment identified Resident #1 was not oriented to person, place or time and had a history of wandering at his/her previous home/facility. The Physician's Orders included an order to admit Resident #1 to the CCDI (dementia) unit on 2/8/2016. The Physician's progress note dated 4/14/2016 revealed	**I**	**$5,000.00** **Held In Suspension**	**Upon Receipt**

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	Resident #1 had a previous elopement at another long term care facility prior to admission to Eldora Specialty Care. The psychiatrist letter dated 5/17/2016 revealed Resident #1 had been evaluated and determined he/she had significant memory loss related to a neurocognitive disorder due to vascular disease. The resident had intact communication skills however his/her decision making capacity was so impaired, he/she would be unable to care for his/her personal safety. The Care Plan identified Resident #1 had a history of negative behavior and refusing personal care such as baths. On 2/4/2016, staff placed a STOP sign across the resident's door while in the room. The Care Plan identified Resident #1 had a potential for impaired communication secondary to dementia, and it identified the resident had exit seeking behaviors, and had a history of leaving a nursing home unassisted with resultant injury. The care plan documented Resident #1 had been admitted at this nursing home via emergency protective services and resided on the dementia unit. The care plan also identified Resident #1 had a history of developing romantic attachments to other residents. On 5/23/2016, the Care Plan added the resident had a window in his/her room did not open and directed staff to provide 15 minute checks and a laser alarm on at night while in room. On 6/2/2016 the Care Plan directed staff to have the laser alarm on at all times while in room to alert staff when out of room. On 6/3/2016 the resident moved closer to the dining room. The Nurse's Notes dated 5/23/2016 revealed the facility housekeeping and maintenance staff observed Resident #1's window screen appeared loose. Staff replaced the			

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	screen and installed locks to prevent the window from opening. Staff initiated 15 minute checks, and the resident denied attempt to exit the facility. Staff informed the Administrator. The Nurse's Notes dated 5/27/2016 revealed Resident #1 asked staff for a screwdriver to help the window rise. The Nurse's Notes dated 6/2/16 revealed staff obtained a urine sample with negative results. Staff noted the laser alarm on at all times when in room and continued 15 minute checks. The Nurse's Notes dated 6/2/16 documented at noon documented the resident had been ambulating in the hallway and looking in other resident rooms. On 6/3/16 the resident moved closer to the dining room and the nurse's station. The Nurse's Notes dated 6/28/2016 at 6:20 p.m., documented staff received a phone call from person inquiring about a resident observed outside the facility. Staff did a room to room check and were unable to locate Resident #1. A facility CNA (Certified Nurse Aide) went and returned with the resident. Staff assessed the resident and notified family and physician. The incident reported dated 6/28/16 at 6:20 p.m., revealed staff received a phone call from a person asking about a [missing resident]. Staff started a search and determined Resident #1 was missing. Treatment sheet for June 2016 documented staff completed his/her wanderguard checks. The 24 Hour Resident Monitor flow sheet dated 6/27 - 6/28/2016 revealed staff failed to document observation of Resident #1 at 6:15 p.m. on 6/28/2016. The Physician Notification Fax dated 6/29/2016			

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	informed Resident #1's physician that he/she eloped from the facility the evening prior through a window. Staff were able to redirect and return the resident to the facility. On 7/5/2016 at 3:55 p.m., the state climatologist reported on 6/28/2016 at 6:15 p.m. the area had a temperature of 75 degrees with mostly cloudy skies. During an interview on 7/6/2016 at 8:30 a.m., the employee of another nursing home (CNA) stated on 6/28/2016 a community member reported going to a ballgame at the high school and noticed Resident #1 sitting on the curb. The community member asked if they had a missing resident. When they asked if they could provide assistance, the resident asked for a ride to Hubbard. She called Eldora Specialty Care to report the incident, went to the resident and stayed until help arrived. The resident had a phone with a dead battery. The surveyor calculated the distance from the facility to the high school at 0.3 miles. During an interview on 7/7/2016 at 9:00 a.m., Resident #1 stated "what the facility is doing here, isn't doing anything for me. A couple of days ago I went for a walk, got out through a window, and it was easy. They brought me back". The resident reported living at another facility prior where he/she climbed out of a window. The resident indicted he/she liked the people at the facility, did not care for the institution, and lived at the two facilities a total of 8.5 years. The resident sat in the room, in the recliner during the interview and expressed a desire to return home. On 7/6/2016 at 3:30 p.m. the DON reported Resident #1 had lived at another long term care facility, and the resident exited that facility when he/she climbed out of a window.			

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	During an interview on 7/5/2016 at 3:05 p.m. and 7/7/2016 at 10:00 a.m., Staff B, CNA reported working the night Resident #1 eloped from the facility. Staff B worked in the main area of the facility and went to the dementia unit to assist with supper at 5:30 p.m. After supper, Staff A gave two showers. At approximately 6:05 p.m., Staff B observed Resident #1 walked to his/her room and Staff B turned on the resident's laser alarm, and shut the door. Staff B took Resident #5 to the bathroom and remained with the resident. When Staff B finished assisting Resident #5, Staff A completed the showers and Staff B left the unit. The facility received a call asking if they were missing a resident. They checked the unit, and failed to locate Resident #1. Staff B observed the window screen had been removed in room #7. Staff B never heard the resident's laser alarm sound because he/she had assisted Resident #5 to the bathroom and had closed the room door and the bathroom door. If Resident #1 quickly turned off the alarm, he/she may not have been able to hear it. The resident had 15 minute checks. At times, it is difficult to complete the checks on time if you are providing cares and you are the only staff in the unit. During an interview on 7/5/2016 at 2:15 p.m., Staff A, CNA reported working in the dementia unit on 6/28/2016 from 2 - 10 p.m. From 2 - 4 the unit had one staff. At 4 o'clock p.m. the nurse or medication aide passed medication in the unit and that is when Staff A took a 30 minute break. From 4:30 - 5:30 p.m. Staff A worked alone in the unit. At 5:30 p.m. they served supper and another aide [Staff B] came to the unit to assist. When the residents finish eating, Staff B left the unit, leaving one aide to complete cares. At 8 o'clock p.m., the nurse or med aide passed medications in the unit, and Staff A went to the floor to assist staff with resident cares. At 8:30 p.m., when the			

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	nurse finished with medications, Staff A returned to the unit and the nurse left. Staff A continued to assist residents with bedtime cares. On 6/28/2016, Staff A had two resident showers to complete, so Staff B remained in the unit after supper to supervise the other residents. At approximately 6 o'clock p.m., Staff A observed Resident #1 sitting at the dining room table, when he/she took a resident to the shower room. At approximately 6:30 p.m., Staff C came to the unit and asked about Resident #1. Staff A had been toileting Resident #5 who had an alarm and could not leave the resident unattended on the toilet. Staff A observed Room #7 had a dresser placed near the window with a drawer removed and placed on the bed [Resident #7's prior room]. The window's screen had been removed and placed along the building. Staff A drove to the high school and found the resident with staff from another facility. The resident got in the car and they returned to the facility. When they reached the facility, the resident refused to get out of the car but finally the Administrator convinced the resident to return inside. The resident had no [physical] signs of injury. The resident asked to go to Hubbard and wore a sweater because he/she planned on being out all night. Staff A never heard the laser alarm sound, and never witnessed the resident turn off the laser alarm. On 7/7/2016 at 9:35 a.m., Staff A reported having difficulty completing the 15 minute checks on time when providing cares such as toileting or putting residents to bed. Sometimes those tasks take longer. At that time [6/28/16], Resident #5 had a chair alarm and staff had to stay with the resident while toileting. When they realized Resident #1 eloped, Staff A had been in the bathroom with Resident #5 at approximately 6:30 p.m. That night, after supper, Staff A gave two showers that took about 10 - 12 minutes each. Staff B had assisted Resident #5 to the toilet during that time. When Staff A completed the showers, Staff B returned to the floor, leaving the unit.			

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	Resident #5 again requested to go to the bathroom, so Staff A assisted the resident to the bathroom. During an interview on 7/5/2016 at 2:50 p.m., Staff C, RN (Registered Nurse) reported working on 6/28/2016 and last observed Resident #1 at approximately 5 p.m. when he/she checked the resident's wanderguard bracelet. Staff C had no observations of the resident attempting to exit the facility. At approximately 6:20 p.m., Staff C received a call from another nursing facility asking if they were missing a resident. Staff C checked the unit and saw Resident #1 had exited the facility. The resident had 15 minute checks at the time due to his/her interest in another resident. The resident had a laser alarm to alert staff when he/she left the room. During an interview on 7/5/2016 at 3:30 p.m., Staff E, Maintenance reported when Resident #1 resided in Room #7, the housekeeper observed the loose window screen. It appeared that the resident may have pushed on the screen. They replaced the screen and installed L brackets to prevent the window from rising. The window had stops in place to prevent the window from rising greater than four inches. It appeared they had been pushed in. When they moved the resident to his/her new room, Staff E moved the L brackets, too. Room #7 had been empty with the door shut since the resident moved out. When they ordered the new windows, they purposely ordered ones with stops in place. All of the windows in the unit had the stops pulled out when installed. After Resident #1 eloped, they installed L brackets on all windows in the unit. During an interview on 7/7/2016 at 9:30 a.m., Staff F, CNA, CMA (Certified Medication Aide), reported they provided 15 minute checks on one resident in the unit, Resident #1. The unit had 9 residents and currently,			

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	they had two residents that required assistance with transfers, two with laser alarms, and two with alarms. At times staff had difficulty completing the 15 minute checks on time if busy taking a resident to the bathroom. At approximately 8:15 a.m., Restorative staff came to the unit to provide exercises with a couple of residents and then left. During an interview on 7/5/2016 at 11:00 a.m., the Administrator reported when Resident #1 exited the facility shortly after supper on 6/28/2016, two staff in the unit were busy providing cares. Resident #1 had resided in Room #7 before being moved to his/her current room. The resident exited the facility through the window in Room #7. The resident pulled out the second drawer of a three drawer dresser, placed it near the window and used it as a ladder. The resident opened the window, removed the screen and placed it nearby, climbed out and shut the window. A passer-by observed the resident sitting on the ground near the high school, and reported it to the other nursing home next door. Staff from that facility went, found the resident and sat with him/her until facility staff arrived. When the resident returned, staff provided a head to toe assessment, and 1:1 supervision until L shaped brackets were installed on all windows in the dementia unit to prevent the windows from rising. The resident had no signs of injury or distress. The resident eloped at his/her prior facility. When the resident resided in Room #7, they noted he/she had tempered with the window screen so they added the L brackets to that window. When they moved the resident to his/her current room, they moved the L brackets to those windows. During an interview on 7/6/2016 at 10:30 a.m., the Director of Nursing (DON) reported the facility attempted to maintain 8 - 9 residents in the dementia unit. The			

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	facility replaced all windows within the last four years, and each window had stoppers that could be pulled out to prevent the windows from rising greater than approximately four inches. In May, housekeeping staff noted that the window screen in room #7, had been tampered with. The facility replaced the screen and added L shaped brackets to prevent the window from rising. In June, the resident moved to a room closer to the dining room. The resident had developed a romantic interest in another resident and the facility separated them, and added laser alarms to both rooms. When they moved Resident #1 to his/her current room, they removed the L brackets from the windows in room #7 and installed them on the window in his/her current room. When the resident exited the facility, he/she must have turned off the laser alarm. Staff A, CNA and Staff B, CNA were in the unit, but were busy providing resident cares at the time. No staff had knowledge of the resident turning off the laser alarm prior. The 15 minute checks log revealed staff saw Resident #1 at 6:00 p.m., no staff visualized the resident at 6:15 p.m. and staff knew the resident had exited the facility at 6:30 p.m. Staff B reported seeing the resident at 6:05 p.m. when he/she went to the room, and Staff B turned on the resident's laser alarm. After the resident eloped from the facility, they installed L brackets on all of the dementia unit windows. The facility updated Resident #1's care plan on 6/28/16 and directed staff to provide 1:1 supervision (visual contact at all times) then moved to 15 minute checks once the L brackets were placed on all the windows on 6/28/16; however the facility did not increase the number of staff in the unit to provide adequate supervision for residents. On 7/7/2016 at 9:50 a.m. the DON reported at the time Resident #1 eloped from the facility on 6/28/2016, the dementia unit had three of nine residents that required			

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	assistance with transfers. Resident #5 and Resident #7 required assistance of one staff for transfers and both had bed and chair alarms. Resident # 6 required the assistance of one staff for transfers and had a floor alarm. **FACILITY RESPONSE**			

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