STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165536	A. BUILDING _____ B. WING _____	C 05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I O O F HOME AND COMMUNITY THERAPY CENTER	1037 19TH STREET SW MASON CITY, IA 50401

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F 000	INITIAL COMMENTS Correction date 5/12/17 The following deficiency relates to the investigation of facility reported incident #67597 & #68027. (See code of federal regulations (42CFR) Part 483, Subpart B-C)	F 000		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff	F 323	Past noncompliance: no plan of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/25/2017

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F 323	Continued From page 1 interviews, the facility failed to provide adequate supervision to protect 1 of 7 residents from hazards. Resident #1 wandered away unnoticed by staff from an offsite facility activity for approximately 30-45 minutes. Staff interviews revealed they were not aware of Resident #1's whereabouts during this time. Observation of area Resident #1 traveled revealed the highway speed limit between 45 to 65 miles per hour; and record review revealed Resident #1 lacked the cognitive skills to make safety decisions. The findings constitute an immediate jeopardy to resident's health and safety. The facility reported a census of 78 residents. Findings include: According to review of the clinical record, Resident #1 entered the facility on 12-08-2015 and had diagnoses which included dementia without behaviors, depression, anxiety, high blood pressure, cardiomyopathy, diverticulitis and irritable bowel syndrome. Documentation in Resident #1's medical record indicated he/she scored 9 (of 15) on the Brief Interview for Mental Status (BIMS) indicating moderate impairment of cognition for decision making skills. The assessment tool also described Resident #1 as requiring staff supervision with most activities of daily living, including bed mobility, transferring, ambulation, eating, toilet use and personal hygiene. Resident #1 required extensive staff assistance with bathing. Review of the facility plan of care identified Resident #1 as being cooperative but restless at times and able to express only very basic thoughts. Resident #1 resided in the memory	F 323	correction required.	

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care unit of the facility and for staff to monitor the resident if restless. Staff were alerted to be aware of the following:
a.) Resident #1 sometimes sees/hears people that others don't. Don't argue with resident's reasoning; attempt to reassure resident of his/her safety. Resident likes to pack his/her items as he/she feels he/she is leaving.
b.) Resident #1 used antidepressant medications and staff are to monitor/document/report PRN (as needed) changes in behavior/mood/cognition; hallucinations/delusions, social isolation, suicidal thoughts, withdrawal, gait changes, balance problems, dizziness/vertigo and fatigue.
An update to the individual plan of care identified a new intervention dated 05-12-2017 which directed staff to provide one to one (supervision) for any activity off campus.
The plan of care indicated Resident #1 was independent with bed mobility and transferring, dressing, personal hygiene and toileting. Resident #1 ambulated independently with a walker. Resident #1 required one staff to assist with bathing.

During an interview on 05-15-2017 at 1:46 p.m. the facility Director of Nursing (DON) stated on 05-11-2017 a small group of residents and staff had gone on an outing. About 3:00 p.m. that afternoon she received a phone call from another Long Term Care (LTC) facility in town wondering if they (IOOF) were missing a resident. The DON stated about the same time a facility charge nurse received a call from staff C stating the group was missing a resident (#1). The DON stated an employee at a cement company had noticed an individual walking, with a walker, toward their office building, which was rather unusual and went to meet the individual. The employee then

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called a LTC facility that was in close proximity to their company. Having all their residents accounted for, that LTC facility called IOOF.

According to a written statement by the facility activity director (AC), (dated 05-11-2017 at 3:21 p.m.) at 1:00 p.m. on 05-11-2017, 7 residents and 3 staff went to the Lime Creek Nature Center for an outing. Staff were each given a list of those residents that were going. Instructions were given to go into the building, see the exhibits and maybe sit out on the patio and watch the birds and animals, then go to McDonalds and get ice cream cones for everyone, but stay in the van. The AC stated she stood on the van steps and asked if anyone had any questions/concerns but no one did. The AC stated about 3:00 p.m. a call was received at IOOF reporting that Resident #1 was lost at the Lime Creek Nature Center, and the caller was wondering what should be done. The AC added that at some point another LTC facility had called IOOF asking if IOOF had a resident missing as the cement company had called them.
The AC explained the facility bus can accommodate two wheelchair dependent residents and 10 ambulatory residents. For the outing on 05-11-2017 one wheelchair bound resident, six ambulatory residents as well as three staff planned to attend. This allowed one staff to supervise two ambulatory residents as well as pushing one wheelchair dependent resident and then two residents to one staff for the other four residents. The AC stated she had taken all the attending residents on community outings at one time or another and felt very confident that this was a very appropriate ratio. She stated all three staff had successfully completed outings together without incident or

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concerns expressed. These staff were hired with their full knowledge that they would be taking IOOF residents into the community on outings. The AC stated the staff (and residents) were going to one building all together and then all back into the same bus to eat ice cream on the bus without getting out again.

During an interview on 05-15-2017 at 4:03 p.m. Staff A stated he was one of the three employees who had accompanied seven residents on the outing to the nature center. Staff A stated upon arrival the individual in the nature center office was notified that they were there, but nothing formal had been set up, so everyone went their own way. Staff A stated they looked at the exhibits and then he and four of the residents sat in a row of purple chairs where they could observe the wildlife activity outside. He stated the bus driver had pushed the wheelchair bound resident outside and then Staff B stated she was going to take another resident outside.
Staff A stated he last observed Resident #1 about 2:00/2:15 p.m. where he/she was just to the left of the group of purple chairs. Staff A stated he thought one of the other employees had Resident #1 and he stated he did not miss him/her until they did a head count shortly before 3:00 p.m. Staff A stated he walked down the main road looking for Resident #1 but did not see him/her.

During an interview on 05-16-2017 at 3:32 p.m. Staff B confirmed that she had been on a facility outing with seven residents and two additional staff. Staff B stated it was her understanding that her job included being responsible for the residents and to account for them all as well as to assist them with ambulation/wheelchair

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locomotion while on an outing. Staff B stated during the outing on 05-11-2017 Staff C went outside with the wheelchair dependent resident and at that time the other six residents and two staff were accounted for. Staff B stated Staff A and four residents were sitting (in the purple chairs). At that time Staff B stated she also went outside with a resident. She stated Staff A remained in the building with five residents. Staff B stated she thought she could have taken care of five residents as "they were just sitting there." Staff B stated she and Staff C (plus the two residents) were outside for 20 to 25 minutes. When they returned back to the building they noticed they were missing one resident. Staff B stated they began to search in the building and around the building and alerted the workers of the nature center to assist in the search. Staff B stated about 3:05 p.m. they were made aware that Resident #1 was found at the cement company.

Staff C's written statement dated 5/11/17 revealed the following: around 2:00 p.m., he had gone to the patio with a resident. Around 2:15 we noticed a resident missing. The resident was inside and one minute gone the next. He reported picking up the resident [Resident #1] at 3:15 after returning back to the nursing home around 3:30 p.m. (Staff C was not available for an interview.)

During an interview on 05-16-2017 at 12:32 p.m. Resident # 5 stated he/she recalled the outing to the nature center. Resident #5 commented that Resident #1 "left" while on the outing. Resident #5 stated Resident #1 did not sit on the purple chairs as she did, and Resident #5 stated he/she

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noticed Resident #1 wasn't with the group when they sat down. Resident #5 stated he/she did not see Resident #1 leave the group but he/she stated she told a staff/employee that he/she hadn't seen Resident #1 for a while and staff began to look for Resident #1.

During an interview on 05-16-2017 at 12:55 p.m. Resident #6 also recalled the outing to the nature center and stated he/she enjoyed those outings. Resident #6 stated one resident left the group and everyone was aware that the resident had left the group and searched for about one half hour. Resident #1 stated they (staff) counted heads every now and then and at the last count they came up short. Resident #6 did not see Resident #1 leave the group nor did he/she know the name of the resident who left.

Observation of the nature center on 05-15-2017 (7:00 p.m.) revealed a long black topped road exiting off the main state Highway 65. The posted speed of the state highway was 45 miles per hour. According to a nature center brochure the maximum speed limit on the black top road was 15 miles per hour. The distance and time to travel the distance by foot was reenacted from the nature center building to the cement company. The distance was 1.01 miles and time to walk the distance was 17:46 minutes. The road was bordered by wooded areas on both sides and on one side there was a small pond with a dock and at another point a gravel parking lot. There were no fences to obstruct or distract entrance to the wooded area.

During an interview on 05-15-2017 at 2:44 p.m. Resident #1 stated he/she recalled taking a long

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walk a few days prior. Resident #1 could not state where he/she had taken the walk, but did indicate that it was so beautiful that he/she thought he/she would "check it out". Resident #1 stated he/she did end the walk in a place where there were big trucks and someone came out and gave him/her a glass of water.

On 5/11/17, the facility made the following corrections after the 5/11/17 incident:
a.) updated the resident's care plan
b.) educated staff all three staff responsible for resident safety
c.) suspended the staff until further investigation.
d.) placed a Wanderguard code alert bracket on Resident #1 on 5/11/17.

The facility updated their Safety and Supervision policy on 5/12/17 to include the following: the Activity Coordinator will assign each resident to a specific staff member for the activity held off campus. The staff member will have the opportunity to review the resident's plan of are and ask question prior to the activity. The activity coordinator will confer with the DON regarding residents that are attending an activity held off campus. During the transportation and activities held off campus, a ratio of one staff member to a maximum of three residents depending on acuity will be obtained. Staff were trained on the revised policy on 5/12/17.