DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166034	A. BUILDING _____ B. WING _____	C 07/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	201 WEST RIDGEWAY AVENUE WATERLOO, IA 50701

(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 VKC 8/3/17 Correction date 7/20/17 The following deficiencies relate to the investigation of complaint #68796 & incident #68831. (See code of Federal Regulations (45 CFR) Part 483, Subpart B-C). Complaint #69456, #69231, #69166, #68886 & #69010 was not substantiated.	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	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Leann Miller — TITLE: Administrator — (X6) DATE: 07/31/2017

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.

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F 323	Continued From page 1	F 323		

appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:

Based on record review, observation and staff and family interviews, the facility failed to ensure the facility provided an environment that promoted safety and well-being, and failed to ensure each resident received adequate supervision to prevent an elopement from the facility for one of six residents with an alert bracelet reviewed. (Resident #4). The facility reported a census of 66 residents.

Findings include:

1. Resident #4 had a MDS (Minimum Data Set) assessment with a reference date of 4/5/17. The MDS indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15. A score of 15 identified no cognitive problems. The MDS identified the resident transferred from an acute hospital setting, required limited assistance of two staff member to transfer between surfaces, ambulate in the room and within the unit with the support of 1 staff member but again required the assistance of two staff members to use the toilet. The MDS indicated the resident had an unsteady balance, able to stabilize without staff assistance while moving from seated to standing position, walking (with assistive device if used), turning around, moving on and off toilet, and transfer between bed and chair or wheelchair. The resident had functional limitation in range of motion of one lower extremity and used a walker and wheel chair for mobility. The MDS reported the resident had diagnoses including hypertension (elevated blood pressure), gastroesophageal reflux, renal insufficiency (kidney disorder), diabetes, thyroid disorder,

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F 323	Continued From page 2	F 323		

arthritis, hip fracture, depression, dislocation of the right hip (subsequent encounter), pain in right hip and muscle weakness with abnormalities of gait. The MDS documented the resident had a fall within the last month prior to admission/entry or reentry, in the last 2 - 6 months, and had a fracture related to a fall in the 6 months prior to admission or reentry. It also indicated the resident had a fall since admission/entry without evidence of injury.

The CAA (MDS worksheet) dated 4/5/2017 included the following analysis of findings: Resident #4 required assistance with ADLs (Activities of Daily Living) with consideration given to the fact the resident had a hip fracture, fall, recent hospitalization, psychoactive medications, and physical limitations. The resident had a fall risk after hospitalization for a hip fracture, then dislocation and revision, arthritis of multiple joints, impaired balance, potential medication side effects, dizziness, limited range of motion of the right lower extremity, self- transferring. Resident at risk for increased dependence on ADLs, increased pain, infection, altered skin integrity and injury. The resident is able to use call light and verbalize needs.

On 4/6/2017 the Care Plan added: Resident #4 had resistive/noncompliant with treatment/care, refusal to remove TED (compression) hose at night, self-removal of Wander Guard related to belief that treatment not needed/working. The Care Plan directed staff to provide education about risks of not complying with therapeutic regimen, give choice and flexibility with ADLs, and if resists care, leave and return later if safe to do so.

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F 323	Continued From page 3 On 3/31/2017 the Care Plan initiated: Resident #4 had an elopement risk related to cognitive impairment with the goal of not leaving center unattended. The Care Plan interventions included: Accompany to meals and scheduled activities, calmly redirect to an appropriate area, check alert bracelet placement every shift and functioning every day. The Care Plan canceled the focus on 4/21/2017. On 4/6/2017 the Care Plan identified Resident #4 had cognitive loss as evidenced by confusion. It directed staff to allow adequate time to respond, approach/speak in a calm, positive/reassuring manner, explain each activity/care procedure prior to beginning it, give two choices when presenting options, identify self, provide cues and prompting for such things as activities, personal care, or room location use patient's name when addressing, use brief and simple words and repeat communication using more than one method. The facility canceled the focus on 4/21/2017. On 4/8/2017 the Care Plan added: Patient shows potential for discharge and patient expresses wish for discharge. It directed staff to complete a discharge plan, discuss with family or representative, investigate need for home health services, and provide education for family/patient to include self-care techniques. On 3/29/2017 the Care Plan included: Resident #4 had a fall risk due to impaired balance/poor coordination, potential medication side effects, unsteady gait, recent right hip fracture and post-surgical dislocation, osteo-arthritis, cardiac disease, chronic kidney disease, diabetes with neuropathy, edema, colostomy, dizziness, impaired cognition and self-transferring. It	F 323		

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F 323	Continued From page 4 instructed staff to administer Calcium and Vitamin D, medications according to physician orders, encourage to transfer and change positions slowly, evaluate medications if patient demonstrates changes in mental status, ADL function, appetite, and neurological status, have commonly used articles within easy reach, provide assist to transfer and ambulate as needed, reinforce need to call for assistance, reinforce wheel chair safety as needed such as locking brakes, report development of pain, bruises, change in mental status, ADL function, appetite, or neurological status per facility guidelines post fall. On 4/4/4017 the Care Plan added: Cardiac disease related to hyperlipidemia (high lipids), and hypertension. Interventions included: administer medication as ordered, assist with activities as needed, encourage to dangle at edge of bed/chair before transfers, encourage to take rest periods as needed, notify physician of heart rate of less than 50, obtain vital signs as indicated, weights as needed, and orthostatic blood pressures as ordered. . On 4/4/2017 the Care Plan added: at risk for complications due to musculoskeletal problems related to dislocation of right hip after surgical intervention for fracture, primary multiple site osteo-arthritis. Goal: Fracture will heal without complications. It directed staff to administer medication as ordered, assist with bed mobility as needed, report evidence of infection, and treatment as ordered. On 3/29/2017 the Care Plan identified the resident had a potential for pain related to complaint of pain of the right hip, recent right hip fracture and post-surgical dislocation,	F 323		

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F 323	Continued From page 5 osteo-arthritis, depression, colitis, reflux, diabetes, neuropathy, and alteration in skin integrity. It directed staff to report expression of pain, administer medication, encourage to reposition frequently to position of comfort, implement non-drug therapies as needed to assist with pain and monitor for effectiveness and notify physician if pain worsens. The Task List Report indicated Resident #4 had an Alert Bracelet, transferred and ambulated with the assist of one and a front wheeled walker initiated on 3/31/2017 and canceled on 4/14/2017. The resident used a walker and wheel chair to move about and had a fall risk. The Physician's orders for Resident #4 included: Weight bearing as tolerated, ordered 3/29/2017. Wander Guard on at all times, monitory for placement and functioning every shift, ordered 3/30/2017, discontinued 4/14/2017. Lovenox, (anticoagulant) 40 mg (milligrams) for DVT (Deep vein thrombosis) daily for ten days. (3/29 - 4/9/2017). Orthostatic blood pressure checks every shift times three days including pulse, making sure readings are taken at least one minute apart for dizziness, ordered 4/6 - 4/9/2017. The Medication Administration Record (MAR) revealed staff checked the resident's Wonder Guard every shift from 4/1 - 4/14/2017 when it discontinued. The 4/8/2017 MAR indicated Resident #4 had a blood pressure of 138/69 on the day shift and 114/65 on second shift. The Progress Notes included:	F 323		

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F 323	Continued From page 6 On 3/29/2017 at 5:13 p.m., Resident #4 arrived to the facility after right hip replacement, alert and oriented times three, had periods of confusion per report and required one assist. On 3/30/2017 at 10:53, Staff A, LPN (Licensed Practical Nurse) documented Resident #4 walked to the bathroom with the walker to brush his/her teeth. The resident reached for the door handle to door leading to the hall, leaned against the wall and fell to the floor. The resident denied pain or hitting his/her head and had normal range of motion. 3/30/2017 at 12:28 p.m., Staff A documented the resident had confusion that morning and talked about leaving and going to school with three to four friends. Staff A placed a Wander Guard on the resident's right ankle. On 3/31/2017 at 1:14, Staff A documented the resident had the Wander Guard on the right ankle. At 9:28 p.m. Staff B, LPN documented the resident was alert and oriented to person with intermittent confusion. The resident spoke of going to school and it pertained to stocks and bonds. In a late entry on 4/5/2017 at 12:29 p.m., Staff C, Social Services indicated the resident recently admitted to the facility for skilled therapies, and alert and oriented to self. The resident's former spouse, present at the time, reported taking care of the resident prior to his/her hip replacement. The former spouse indicated the resident had some confusion but it appeared to worsen with anesthesia.	F 323		

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F 323	Continued From page 7 On 4/6/2017 at 1:07 a.m., Staff D, LPN observed the resident had no Wander Guard on. The resident reported tired of the noise, removed it and threw it in the trash can. Staff D re-applied the Wander Guard [bracelet]. At 7:19 a.m., Resident #4 revealed he/she used a scissors to cut off the Wander Guard and placed it in the red overnight bag. The resident used the cuticle scissors that he/she used to open the ostomy appliance. The resident allowed staff to lock the scissors up for safekeeping. On 4/6/2017 at 11:57 a.m., staff documented Resident #4 worked with Occupational Therapy and complained of feeling dizzy after ambulating several feet. The resident's blood pressure (BP) read 117/55, heart rate at 92 (normal is 60-100) while sitting, and BP 64/35 with heart rate of 62 while standing. The resident also reported a "bad taste" in his/her mouth and blurred vision. Staff notified the physician and received orders to check blood pressures every shift for three days and encourage fluids. On 4/6/2017 at 1:17 p.m., staff observed the resident trying to leave the facility and stated he/she had an appointment at 2:30. Staff explained the resident needed to stay at the facility so they could monitor blood pressure and dizziness. The resident denied feeling dizzy. Staff redirected the resident back to the room. On 4/7/2017 at 9:12 a.m. staff documented the resident was alert and oriented to name and situation with forgetfulness, and denied dizziness. On 4/8/2017 at 5:38 a.m., Staff D, LPN indicated the resident had a Wander Guard on the right ankle and it functioned.	F 323		

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F 323	Continued From page 8 At 12:08, Staff A, LPN documented the resident was alert and oriented with some confusion at times, had no complaint of dizziness and denied pain and discomfort at that time. At 2:15 p.m., Staff E, RN (Registered Nurse) indicated Staff C, Social Worker came to the desk and asked for Resident #4. Staff checked the room, bathroom, therapies, and dining room and failed to locate. Staff called the family at 2:40 p.m. with no answer. Staff called the other family and got the son-in-law who gave Staff E the resident's cell phone number. Staff called the number, located the resident at the local bank and picked the resident up. Staff called the family and let them know the resident had been located. Staff assessed the resident. At 5:41 p.m. Staff C indicated they informed Resident #4's daughter that the resident went to the bank and the facility locked up the cash in a facility safe. Staff C discussed discharge planning at that time and family indicated they considered an Assisted Living facility. At 5:50 p.m. Staff C revealed he/she completed a MDS assessment and determined Resident #4 had intact cognition and no depression. Staff C indicated the Wander Guard had been placed on the resident upon admission as a precaution related to orthostatic blood pressures and falls that could contribute to confusion. On 4/8/2017 at 10:35 p.m. Staff E reported Resident #4 had pain rated at 3 on a scale of 1-10 in his/her groin area. Staff administered Tylenol.	F 323		

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F 323	Continued From page 9	F 323		

On 4/9/2017 at 5:48 a.m., Staff D reported the resident had a Wander Guard intact and functioning on the right ankle with no elopement ideation noted.

On 4/10/2017 at 12:55 p.m., Staff noted the resident ambulated with a wheeled walker and did not wait for assistance even with reminders. Staff educated the resident. The resident failed to use the call light. Staff observed the Wander Guard intact to the right ankle. The resident had no attempts to leave the facility without assistance.

On 4/10/2017 at 4:45 p.m. Resident left the facility with family, went out to dinner and returned at 6:15 p.m.

In a Late Entry on 4/11/2017 at 9:15 a.m., Staff C revealed he/she notified the resident's family that the resident's insurance coverage would discontinue and of the intended discharge date of 4/1/4/2017.

On 4/13/2017 at 12:58 a.m., Staff D documented the resident had a Wander Guard on the right ankle.

On 4/14/2017 at 12:34 a.m., Staff D noted the resident had a Wander Guard on the right ankle. On 4/14/2017 at 12:12 p.m. Resident #4 discharged home. The resident left walking stable without an assistive device.

The Physical Therapy (PT) Evaluation and Plan of Treatment with a start dated of 3/30/2017 included the following documentation related to Resident #4:
Referral Reason: Patient referred to PT due to exacerbation of decrease in strength, decrease in

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F 323	Continued From page 10 functional mobility, decrease in transfers, reduced activity tolerance, paralysis/paresis, reduced ADL participation and increased need for assistance from others indicating the need for PT to increase independence with gait, promote safety awareness, improve dynamic balance, increase activity tolerance and lower extremity range of motion and strength and facilitate discharge planning. History/complexities: Patient with history of right hip fracture 1/18/2017 and right hip dislocation 1/29/2017, went to a nursing home and then home. Fell 3/24/2017 with dislocation and to Emergency Room for hip relocation. Home with hip Spica (brace). Had severe pain and back to hospital on 3/25/2017 and 3/27/2017 had right total hip. The PT Discharge Summary dated 4/13/2017 revealed the resident required supervised ambulation with a walker due to safety/cognitive issues. The resident had inconsistent step sequence without cues when ascending/descending 5 stairs. Education provided to patient and caregiver for safety/technique with gait on levels and stairs; hip precautions. Discharged home with home health, therapy evaluation and treat. Payer source changed. Recommend Assisted Living Facility, home exercise program and assistive device for safe functional mobility. Resident #4's Occupational Therapy Discharge Summary: 4/13/2017. ADLs and IADLs (Instrumental Activities of Daily Living) required supervision at discharge. Resident #4's Admission assessment form dated 3/29/2017 did not reveal the resident had exit	F 323		

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F 323	Continued From page 11 seeking behaviors: No history of exit seeking, no history of wandering and no verbalizing desire to exit. The Physician Progress Note dated 4/7/2017 identified Resident #4 hypotensive (low blood pressure) on 4/6/2017. The physician discontinued the residents Lisinopril (blood pressure medication). The resident denied feeling dizzy or lightheaded. The physician Discharge Summary dated 4/12/2017 reported Resident #4's stay at the facility had been generally unremarkable, blood sugars were initially consistently running low so the Novolog (insulin) had been discontinued and the blood sugars remained stable and controlled with the Lantus (insulin). The resident also had dizziness determined to be orthostatic (blood pressure), and ordered Lisinopril held if systolic blood pressure read less than 100. The resident made good progress in therapies and had no concerns. Staff had no concerns either. The resident planned to go home for a short period of time before moving to an Assisted Living Facility in Arizona. During an interview on 7/14/2017 at 2:20 p.m., Resident #4's son-in-law reported he received a call from the facility on 4/8/2017 at approximately 2:50 p.m. asking if the resident was with family. The facility indicated they were not sure of the resident's whereabouts, and an employee had seen the resident walk out of the facility. The son-in- law stated he gave the facility the resident's cell phone number. A couple of minutes later, the son-in-law called the resident but got no answer. The son-in law stated at approximately 2:58 p.m. the facility called and informed him they got in	F 323		

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F 323	Continued From page 12 touch with the resident at the bank and they were going to get him/her. During an interview on 7/14/2017 at 10:00 a.m., Resident #4's daughter revealed the facility had called asking if family had the resident with them. The facility said they did not know where the resident went and did not know how to contact him/her. The daughter indicated she worked the night shift and therefore slept during the day. They later called her spouse to say they had found the resident. The daughter indicated she always signed the resident out when taking the resident out of the facility. At approximately 5:30 - 6:00 p.m., the daughter called the facility. Whoever answered indicated he/she knew nothing of the incident and transferred the daughter to the Administrator and she had a conference call with the Director of Nursing (DON) and the Social Worker. They asked the daughter if the resident had ever been at another facility. The daughter informed them that the resident had been at another facility for rehabilitation after surgery. They informed the daughter that the resident went to the bank, but they never explained how the resident got there. The daughter assumed someone went with the resident to the bank. They told the daughter that the resident took money out and asked for permission to lock it up. She thanked them for locking it up. They asked if it was okay for the resident to go to the bank and she said yes. They never said the resident cut off his/her Wander Guard and they never said the resident walked without the walker (assistive device). The resident never said anything to the daughter about calling a cab. The resident thought a social security check had been deposited and he/she wanted to withdraw money. The resident told the	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	201 WEST RIDGEWAY AVENUE WATERLOO, IA 50701

(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 13 daughter a good samaritan woman picked him/her up along the way and he/she was limping. The resident told the daughter he/she walked out of the facility through the double doors following a gentleman in a wheel chair, and nobody stopped him/her. The daughter said it scared her to think about the incident. The resident obviously knew to cut off the Wander Guard. On 6/30/2017, Staff G (Administrator) was interviewed and reported being in his/her office on 4/8/2017 at 1:30 p.m. when Resident #4 stopped and said he/she intended to go to the bank. Staff G knew the resident was going to the bank without the walker. Staff G asked the resident if he/she told the nurse and the resident said "yes". The resident told Staff G he/she planned to go to the bank by Walgreens. Staff G stated the resident had gone to Walgreens in the past. The Wander Guard alarm failed to sound. Staff G, did not know Staff C, Social Worker had been looking for the resident. Staff G stated she had no knowledge of anyone looking for the resident. Staff G sat in the office with the door shut. The resident went to the bank, withdrew a couple of hundred dollars and they locked it up. The resident had a BIMS of 15 and had informed staff. The facility did not consider it an elopement. Staff G did not know who found the Wander Guard. They reviewed the video of the front door exit and saw the resident ambulated out the door without a walker and the alarm failed to sound. Staff H, Receptionist watched the resident leave. On 7/12/2017 at approximately 2:45 p.m., Staff G stated on 4/8/2017, the facility called a Code Green (missing person). They reviewed the procedure and looked at the normal trigger	F 323		

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F 323	Continued From page 14 points. Staff G stated the resident told staff he/she called a cab and they failed to see that as a problem. They did notice the resident failed to sign out on the Leave of Absence sheet. Staff G stated the alert resident had a means of communication and they knew the resident would soon go home. At shift change report, there had been confusion. The video showed the resident went from the hall past the front desk, stop and talk to Staff H and walked out the front door wearing plaid pants and a shirt. The resident told Staff H he/she intended to go to the bank and would be right back. An hour before the resident left, Staff G went to the resident's room and the resident told Staff G he/she intended to go to the bank. Staff G told the daughter the resident went to the bank alone and she was happy he was independent and strong enough. The resident had a high BIMS score and Staff G did not see the incident as reportable. They failed to see where anything should have been done differently other than the resident should have signed out. Staff G stated the facility had no other residents who removed the Wander Guard bracelet. During an interview on 6/30/2017 at 12:10 p.m., Staff I, Director of Nursing stated she received a call at home on April 8 from Staff C, Social Worker. Staff I stated Resident #4 was supposed to be outside but went to the bank and staff went to pick the resident up. Staff I came to the facility after the resident had returned. Staff I stated Staff J, RN did an assessment. They wanted to make sure the resident was not exhausted. The resident indicated he/she went to the bank to get money out. Staff I stated she heard the resident got a ride. The resident told staff they would find the Wander Guard in the red suitcase. Staff I	F 323		

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F 323	Continued From page 15 stated it appeared the resident used a finger nail clipper to cut it off. Staff I stated Staff K, Maintenance, pulled out the suitcase and found the Wander Guard. By the time Staff I arrived to the facility, someone had already applied a new Wander Guard. Staff I talked to everyone. Staff H reported the resident said he/she was going outside. Staff A revealed the resident mentioned wanting to cash a check. The resident should not have had a Wander Guard on with a BIMS of 15. The facility had an exit seeking book with photographs of residents with Wander Guards. At that time, Resident #4's photo and name would have been in the book. The resident discharged on April 14, 2017 with plans to go to an Assisted Living in Arizona. Staff I stated that Staff H worked at the facility a couple of months and check Wander Guard placement every shift. The DON stated the resident did not sign out of the building on 4/8/17. The resident never mentioned wanting to go home. On 7/13/2017 at 11:35 a.m., Staff I (DON) reported Staff L, Dietician, picked up Resident #4 at the bank at 2:15 p.m., and returned with the resident at 2:30 p.m. On 6/30/2017 at approximately 8:15 a.m., Staff C, Social Services reported on 4/8/17 she looked for Resident #4 at approximately 2:00 p.m. to ask a question about discharge. Staff C asked Staff J, RN if she knew where the resident had gone. The resident had at times gone out with family. Some staff indicated the resident mentioned going to the bank. Staff C stated that Staff J called the resident's family, got the resident's cell phone number, called it and found the resident went to the bank.	F 323		

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F 323	Continued From page 16 During an interview on 6/30/2017 at 11 a.m., Staff J, RN reported working second shift on 4/8/17, when Resident #4 went to the bank. During report, Staff C asked if they had seen Resident #4. Later, Staff C returned and indicated they failed to locate the resident. Staff J called the resident's family and obtained the resident's cell phone number. Staff J called the resident at the bank and Staff L went to get the resident. Upon return, Staff J did a head to toe assessment. The resident had no Wander Guard on and the resident reported removing it. Later, someone said they found it. Staff J never completed an Incident Report. The resident appeared alert and oriented and answered questions. When Staff J asked the resident why he/she failed to inform staff about going to the bank, the resident replied "it was my business". Staff J stated the resident had previously mentioned wanting to go home. During an interview on 6/30/2017 at 12:30 p.m., Staff H, receptionist reported at 1:30 p.m. a resident wearing plaid pants came up and said "it's a beautiful day" and wanted to sit outside. The door alarm did not sound. When residents sit out front, staff checks on them every 15 minutes and offer them water. The resident sat on the bench at the first 15 minute check and refused water. At 2:00 p.m., Staff C came looking for Resident #4 and failed to find him/her. The facility called a Code Green. Staff G, Administrator came out of the office and helped looking for the resident. Staff G never said the resident went to the bank. Nobody knew the resident went to the bank. Staff H stayed at the desk to monitor. Staff F, dietician brought the resident back. The resident reported feeling fine and he/she just went to the bank. Staff H reported being happy to see the resident's face. Staff H reviewed the	F 323		

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F 323	Continued From page 17 facility Exit Seeking book. If the resident had a Wander Guard on, the alarm would have sounded. Staff H would have re-directed the resident away from the door and called a staff member to take the resident away from the area. During an interview on 6/30/2017 at 9:00 a.m., Staff L, Dietician reported working in the kitchen on Saturday, 4/8/17. Staff C, Social Services asked Staff L to get Resident #4, sometime in the afternoon, around 2:00 p.m. Staff L picked the resident up at the local bank. The resident told Staff L he/she walked to the bank and had business to do. The resident had no walker when he/she got into the car with Staff L. During an interview on 7/11/2017 at 11 a.m., Staff A, LPN reported working from 6 a.m. - 2 p.m. on 4/8/17. Staff A stated between 9:00 and 10:00 am, Resident #4 came to the nurse's station and requested a phone number for a taxi cab. The resident indicated he/she had a $10 check to cash. The resident used a phone book and returned to his/her room. The resident never mentioned going to the bank again that day. That morning, Staff A checked the resident's Wander Guard and found it on and functioning. The resident made no other remarks about leaving and had no other attempts to leave. After lunch, Staff A observed Resident #4 ambulating near the back nurse's station. At the change of shift, someone asked about the resident's whereabouts. Staff A stated the staff looked in the resident's room and outside and they called a Code Green. Staff A an incident report was not completed since the resident was alert. Staff A heard the resident removed the Wander Guard. During an interview on 7/11/2017 at	F 323		

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F 323	Continued From page 18	F 323		

approximately 2:55 p.m., Staff M, RN reported working on 4/6/2017 and the resident thought he/she had a doctor's appointment. Staff M found the resident standing at the end of the hall with a walker and a coat, and reported waiting for a cab. Staff M reported the resident had the wrong day. The resident became upset and family came and calmed the resident down. Staff M stated If a resident had a Wander Guard, they are not allowed to leave the premises.

During an interview on 7/12/2017 at 11:50 a.m., Staff S, RN reported the facility has a book at the receptionist desk. The book contains photographs of residents with an elopement risk and with Wander Guards.

During an interview on 7/13/2017 via phone, Staff B, LPN reported working the day shift on all units. Resident #4 initially had confusion, and then became less confused and eventually cleared. Staff B heard the anesthesia caused the confusion. Staff B observed the resident ambulating with therapy.

During an interview on 7/12/2017 at approximately 4:10 p.m., Staff X, OT (Occupational Therapy) revealed at discharge, Resident #4 required assistance with ADLs and IADLs. IADL, or Independent Activities of Daily Living, includes tasks such as cleaning, cooking and household management. Resident #4 had impulsive behaviors, decreased memory and decreased safety awareness. Sometimes the resident remembered hip precautions and other times, not. The resident would require supervision with community mobility such as going to a grocery store or a bank. The resident had a concern for safety due to cognitive issues and

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F 323	Continued From page 19 ambulated with supervision. During an interview on 7/18/2017 at approximately 10:30 a.m., Staff Y, PT (Physical Therapy) stated Resident #4 had a history of dislocating the hip more than once. Staff Y stated the resident had dizziness for a couple of days and that resolved. Staff Y entered the resident's room one day and found the resident standing at the foot of the bed without a walker; a safety concern. The resident had inconsistent follow through. When the resident used the walker, he/she could ambulate independently. Staff Y stated due to cognitive/safety issues, Staff Y recommended supervision. The resident may not always react to safety concerns. The walker provided support and slowed the resident down. During an interview on 7/12/2017 at approximately 10:30 a.m., Staff N, CNA reported working on Resident #4's hall during the day shift on 4/8/2017. The resident never gave any indication he/she intended to leave the facility. Staff N stated never knew the resident had a Wander Guard, the nurses check it. Staff N stated had no knowledge if the resident had any other attempts at leaving unattended. Staff N stated she assumed if the resident had a Wander Guard it was due to wandering off. During an interview on 7/11/2017 at approximately 2:35 p.m., Staff P, CNA reported working second shift on 4/8/2017. Staff P never witnessed any attempt to leave, nor did the resident mention wanting to leave. Normally when residents can walk by themselves, they have a Wander Guard. On 7/11/2017 at approximately 10:05 a.m., Staff	F 323		

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F 323	Continued From page 20 Q, CNA reported working second shift on 4/8/2017. They had just finished report and someone called a Code Green. Everyone looked for Resident #4 checking bathrooms and resident rooms. Nobody knew the resident went to the bank. On 7/13/2017 at 12:45 p.m., Staff Q indicated the resident appeared confused about 60% of the time. The resident said things like "going to a meeting, committee members are waiting ". During an interview on 7/13/2017 at approximately 2 p.m., Staff V, CNA reported working on second shift. Some days Resident #4 required assistance and other days the resident could do his/her own cares. The resident forgot to use the walker at times. At times the resident had a little confusion and failed to know where he/she was at. On 7/12/2017, Staff T, Receptionist reported working Monday through Friday, and one weekend a month. Staff T showed the surveyor the Exit Seeking binder with photos of residents. When residents sit outside, they check on them every fifteen minutes, especially during hot weather. Staff T did not recall Resident #4 attempting to leave. During a phone interview on 7/11/2017 at 2:20 p.m., the state climatologist reported on 4/8/2017 at 1:54 p.m. the Waterloo area had a temperature of 74 degrees, clear skies and breezy conditions. A review of the area between the facility and the local bank identified a 1 mile distance. The facility faced Ridgeway Avenue (East/ West) with 35 miles per hour speed limit. It sat next to Walgreens' pharmacy and used the same street	F 323		

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F 323	Continued From page 21 entrance from Ridgeway. Ridgeway intersected with Kimball (North/South), a four lane road with a 35 miles per hour speed limit. The bank faced San Marnan (East/West), a four lane road with a 45 miles per hour speed limit. There were stop lights on Kimball at Park Lane, Rachel and Brookeridge. The distance between the facility and the local bank had a partial side walk. The Manor Care Health Services, Leave of Absence sign out sheet revealed the resident had been signed out two times. Resident #4's daughter signed the resident out on 4/3/17 at 4:47 p.m. and 4/10/17 at 4:45 p.m. The facility completed a Missing Resident Drill on 4/8/2017 on second shift, initiated at 2:20 p.m. It revealed the facility had an appropriate response and completed a review of the procedure. The Missing Patients Response Plan dated May, 2011 included: Introduction - The Missing Patient Response Plan is intended to provide guidelines for patient accountability, searching for missing patients and communicating with outside agencies. This plan supplements the most current clinical services information regarding missing patients. I. Identification of Missing Patient A. Use the Missing Patient Actions Table and Missing Patient Locator Form to document all actions taken during the search. B. Upon determining that a patient cannot be located, the nursing supervisor will immediately notify the location manager and Administrative Director of Nursing Services. C. Conduct a page and/or head count as determined by the situation to locate missing	F 323		

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F 323	Continued From page 22 patient. II. Patient Care Area Searches A. All nursing staff will return to their areas and in a discreet manner search all areas accessible to patients. B. As each area is searched, the results will be given to the location manager/command post. C. A center floor plan will be used to make sure all areas are searched. III. Searching Other Areas of the Center A. Departments, other than nursing will search their own public and private areas and report the results to the command post. B. Other public areas such as the lobby, beauty shop etc. will be searched by administration and business office staff. C. Exterior will be searched by maintenance and available staff once released from their own departments. IV. External and Off-Premises Searches A. Off-premises searches will be coordinated with the local emergency response agencies B. Search teams will be equipped with cell phones and search kits C. Search teams will concentrate on areas such as nearby shopping centers, social clubs, churches and locations the patient may be familiar with V. External Notification External Notification will be initiated if the patient is not located in a reasonable amount of time, based on the patient's physical and mental condition. Factors such as extreme temperatures or if there is a chance of violence or suicide will be considered in determining a reasonable	F 323		

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F 323	Continued From page 23 amount of time for the search before notifications are made. A. Families/Guarantors will be contacted B. The police department will be contacted and provided the information C. The admitting physician is notified and advised of the circumstances. D. State licensing agencies are contacted as required E. Records will be maintained of all external contacts and if possible immediately confirmed by fax or e-mail. VI Actions When Patient is Located A. Page twice: "all clear: to staff. B. Examine the patient and record findings in the chart C. Notify family/guarantor, police, admitting physician and state licensing agency D. Administer any late medications per physician orders E. Prepare follow up Occurrence Investigation. F. Take immediate actions to prevent further wandering, exit seeking, etc. until a full review of the Care Plan can be completed regarding exit seeking behaviors. Note: At the time of the complaint investigation, the complaint was coded at a "J" immediate and serious jeopardy. By 7/12/17, the facility had implemented meaasures that adequately addressed the jeopardy and the grid placement was lowered to the "D" level. On 7/12/17, all nursing staff and Department Heads received education about signs and symptoms of impending elopment, checking the sign out sheets at the nurses' stations if a patient is unable to be located prior to calling a Code Green (Missing Person Alert). The Administrator or	F 323		

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F 323	Continued From page 24 designee will check the nurses' stations to the patient sign out book is in place, along with a sign out book at the front entrance. The book placement will be viewed during the daily rounds by the Administrator/Designee and by weekend manager on the weekends. As of the 7/19/17 exit conference, the facility continued to need to: Monitor resident with wander guard devices to ensure the devices are located on the resident and have not been removed by the resident. Continue to monitor impending elopement signs and symptoms of residents that may have a change of condition in mental status. Continue to monitor the sign out books at the front entrance and at the nurses' stations. Continue to follow the policy and procedures for the Missing Person Alert (Code Green).	F 323		

ManorCare Health Services-Waterloo
201 W. Ridgeway Ave.
Waterloo, Iowa 50701

This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Iowa Department of Public Health. Preparations and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

F323
The facility strives to ensure that –

1) *The resident environment remains as free of accident hazards as is possible;*
2) *And that each resident receives adequate supervision and assistance devices to prevent accidents.*

Corrective action taken for residents found to have been affected by deficient practice
Resident #4 no longer resides in the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents who have an alert bracelet have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Nurses will continue to monitor placement of alert bracelets on residents identified as an elopement risk every shift on an ongoing basis.
- Director of Nursing or designee will monitor patients who have a change of condition in mental status for signs and symptoms of impending elopement x 4 weeks.
- Administrator or designee will visualize that the resident sign out books are at the front entrance and each nurses' station daily x 4 weeks.
- Director of Nursing or designee will conduct random Missing Person (Code Green) drills twice a week x 4 weeks.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.

July 20, 2017

PRINTED: 08/01/2017
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

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MANORCARE HEALTH SERVICES	201 WEST RIDGEWAY AVENUE WATERLOO, IA 50701

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N 104	50.7(4) 481- 50.7 (10A,135C) Additional notification 481-50.7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(4) When a resident elopes from a facility. For the purposes of this subrule, " elopes " means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff. This Statute is not met as evidenced by: Based on record review and staff interviews, the facility failed to report a resident elopement as required. The facility census was 66 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 4/5/17, revealed Resident #4 had a BIMS score of 15 that indicated no cognitive impairment and required limited assistance of one staff to transfer and ambulate in the room and within the unit, and required assistance of two persons to use the toilet. The MDS indicated the resident had unsteady balance, able to stabilize without staff assistance while moving from seated to standing position, walking (with assistive device if used), turning around, moving on and off toilet, and transfer between bed and chair or wheelchair. The resident had functional limitation in range of motion of one lower extremity and used a walker and wheel chair for mobility.	N 104		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Leann Miller — TITLE: Administrator — (X6) DATE: 07/31/17

PRINTED: 08/01/2017
FORM APPROVED

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
	IA0726	A. BUILDING: _____ B. WING _____	C 07/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	201 WEST RIDGEWAY AVENUE WATERLOO, IA 50701

(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
N 104	Continued From page 1 Progress Notes dated 4/8/2017 at 5:38 a.m., documented Staff D, licensed practical nurse, LPN indicated the resident had a Wander Guard on the right ankle and it functioned. At 12:08 p.m., Staff A, LPN documented the alert and oriented resident had some confusion at times, had no complaint of dizziness, and denied pain and discomfort at that time. At 2:15 p.m., Staff E, registered nurse, RN indicated Staff C, Social Worker came to the desk and asked for the resident's location. Staff checked the resident's room, bathroom, therapies, dining room and failed to locate the resident. Staff called the family at 2:40 p.m., with no answer. Staff called the son-in-law who gave Staff E the resident's cell phone number. Staff called the number, located the resident at the bank, and staff picked the resident up. Staff called the family and let them know the resident had been located. Staff assessed the resident. At 5:41 p.m., Staff C documented they informed the resident's daughter that the resident went to the bank and the facility locked up the resident's cash in a facility safe. On 6/30/2017, the Administrator reported being in his/her office at 4/8/2017 at approximately 1:30 p.m., when the resident stopped and said he/she was "going to the bank". Staff G knew the resident intended to go to the bank without the walker (assistive device). Staff G asked the resident if he/she told the nurse and the resident said "yes". The resident told Staff G he/she was going to the bank "right here by Walgreens". Staff G indicated the resident had gone to Walgreens in the past. The Wander Guard alarm failed to sound. Staff G, did not know Staff C, Social Worker had been looking for the resident. Staff G had no knowledge that staff looked for the resident. Staff G sat in the office with the door shut. The resident went to the bank, withdrew a	N 104		

PRINTED: 08/01/2017
FORM APPROVED

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
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N 104	Continued From page 2 couple of hundred dollars and they locked it up. The resident had a BIMS of 15 and had told them were he/she intended to go. The facility did not consider it an elopement. On 7/12/2017 at approximately 2:45 p.m., Staff G revealed on 4/8/2017, the facility called a Code Green (missing person), they reviewed the procedure and looked at the normal trigger points. The resident told staff he/she called a cab and they failed to see that as a problem. They did notice the resident failed to sign out on the Leave of Absence sign out sheet on April 8. The alert resident had a means of communication and they knew the resident would soon go home. At shift change report, there had been confusion. The Manor Care Health Services, Leave of Absence sign out sheet revealed 2 sign out times. Resident #4's daughter signed the resident out on 4/3/17 at 4:47 p.m. and 4/10/17 at 4:45 p.m.	N 104		

ManorCare Health Services-Waterloo
201 W. Ridgeway Ave.
Waterloo, Iowa 50701

This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Iowa Department of Public Health. Preparations and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

N104
The facility strives to ensure that –

1) *They notify the director or director's designee within 24 hours, or the next business day, by the most expeditious means available of when a resident elopes from the facility.*

Corrective action taken for residents found to have been affected by deficient practice
Resident #4 no longer resides in the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing within the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Administrator and Director of Nursing reviewed chapter 50.7(4) on notification of the director or director's designee concerning resident elopements.
- Administrator and Director of Nursing will investigate all missing person incidents and report according to the regulation set forth in chapter 50.7(4).

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.

July 20, 2017