STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165513	A. BUILDING _____ B. WING _____	C 08/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR RETIREMENT HOME	3131 HILLCREST ROAD DUBUQUE, IA 52001

(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 The following information is related to the investigation of facility reports #67904, #69661, #68150, #67293 and #69152-M. See code of Federal Regulations (45 CFR) 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 clinical record review, observation and staff and resident interviews the facility failed to	F 323	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/29/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 1 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 four residents reviewed regarding supervision. (Resident #1). Record review identified Resident #1 with prior attempts to exit the nursing home. On 7/30/17, Resident #1 exited the facility and his/her alarm device sounded to alert staff. Staff turned off the alarm without identifying who alarmed the door and approximately 20 minutes later, staff discovered Resident #1 was missing. Resident #1 crossed two busy streets and arrived at the nearby grocery store. In addition, 1 hour prior to the elopement, staff interviews revealed they had witnessed Resident #1 enter the key code successfully on a different door and failed to ensure the resident would receive adequate supervision. The findings constitute an Immediate Jeopardy situation. The facility reported a census of 94 residents. Findings include: 1.Resident #1 admitted to the facility on 6/1/2017 from an acute care setting. The hospital History and Physical (H & P) revealed the resident admitted to the hospital on 5/24/2017 on a voluntary basis and had diagnoses including dementia, frontal lobe type with behavioral and psychological symptoms, diabetes and mood disorder. The H & P revealed the resident had progressively declined from a functional standpoint, had limited orientation, behavioral outbursts and had suicidal thoughts at home. The H & P also reported the resident had a childlike presentation consistent with frontotemporal	F 323		

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F 323	Continued From page 2 dementia. The Minimum Data Set (MDS) dated 7/27/2017 revealed the resident had moderately impaired decision making skills, cues/supervision required and short and long term memory problems. The MDS reported the resident had wandering and other behavioral symptoms not directed at others, transferred and ambulated in the room independently and required limited assistance at times in the corridor with the use of a walker. The Care Plan identified Resident #1 had a behavior problem initiated 6/13/2017, as evidenced by wandering. It directed staff to provide interventions including behavior monitoring program, intervene as necessary to ensure safety and privacy of resident and others, and reinforce appropriate personal boundaries with other residents. On 6/17/2017 the Care Plan added: Unit exit codes will be changed to prevent elopement. On 6/19/2017 the Care Plan added: Be aware of residents when going out of exit doors with code. On 6/20/2017 the Care Plan added: Redirect from doorway with music and i-pod when trying codes. On 7/30/2017 the Care Plan added: 15 minute checks with documentation to include if at the door. The Care Plan failed to include the resident had a Wanderguard/Roam Alert bracelet. The elopement/wandering assessment dated 6/2/2017 revealed Resident #1 had an elopement/wandering risk. The Interdisciplinary (ID) Notes dated 7/30/3017 included: At 8:51 a.m. - Resident #1 had been exit seeking and had bag packed on his/her walker.	F 323		

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F 323	Continued From page 3 Re-directed to family room. At 3:08 p.m. - Staff in SVS (Sunshine Valley Suites) unit could not find resident, code green called per protocol. See incident report for details. At 3:11 p.m. - Staff noted resident wore appropriate summer outfit with outside temperature at 79 degrees Fahrenheit. Water provided on return to facility for hydration. The ID Notes dated 7/17/2017 at 11:32 a.m. revealed staff observed the resident had no roam alert bracelet on and replaced it on the walker. The resident reported it bothered his/her leg. The ID Notes dated 6/17/2017 at 7:34 a.m. reported Resident #1 exited the facility. Alarms sounded indicating the SVS patio door had been opened. The roam alert sounded indicating the SVS patio door opened. Staff found the resident just outside the door on the cement slab. Staff redirected the resident to the building. Resident exited the unit door by entering the code. Staff were busy and the resident left unwitnessed. Staff believed the resident knew the codes to the tub door and the main door exits. Care Plan updated and codes will be changed. The July, 2017 Roam Alert form revealed staff observed Resident #1 had a Roam Alarm on July 29 and July 30. The Incident Report dated 7/30/2017 revealed Resident #1 eloped from the unit. The resident had been eating lunch when staff were toileting residents after lunch. Staff failed to find the resident and called a Code Green (Missing Persons) and staff were sent to assigned locations. One staff sent in car and located the resident between Fareway and Dollar Tree. The resident got into the car without incident and returned. The resident indicated he/she planned	F 323		

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F 323	Continued From page 4 to go home. Staff initiated 15 minute checks upon return. The surveyor noted an approximate 0.2 mile distance between the facility and Fareway grocery store. The path from the nursing home to the grocery store showed two busy streets that Resident #1 would have crossed to arrive at the location where staff found him/her. The State Climatologist reported on 7/30/3017 at 1:00 p.m., Dubuque had 76 degrees Fahrenheit weather with calm winds and clear skies. Observation on 8/1/2017 at 2 o'clock p.m. revealed Resident #1 in the activity room watching television. The resident appeared calm, clean and neat with appropriate behaviors. At 3:55 p.m. the resident sat in the bedroom in a recliner chair with shoes off and feet up. The resident had eyes shut and appeared calm and restful. On 8/2/2017 at 3 o'clock p.m. the resident sat in the room in a recliner watching the i-pod. The resident responded to questions: Question: Have you been out of the facility lately? Answer: On Sunday I was out a little, I walked a little bit. I wanted to go to my house, I have a bird and a puppy. My sister has my puppy and we call her Molly. We took Molly to the doctor and she is happy. Question: Did you tell anyone? Answer: I can't do it any more. Bad. I had this thing (resident pointed to walker). Question: How did you leave here? Answer: I pressed that button and walked out. I put my stuff in a bag, but now I cannot do it anymore. Question: How come you cannot do it anymore?	F 323		

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F 323	Continued From page 5 Answer: I don't know the numbers. Dr. said I could go home in winter. I want my puppy, bird and friends. Question: Did someone pick you up? Answer: One of the girls here, it was lunch and that's how they noticed it. I like Dubuque. Question: What is the name of this place? Answer: Can't remember. Question: What day is it? Answer: Wednesday. Question: Do you have children? Answer: No, I had a spouse but he/she was bad. During an interview on 8/15/2017 at 11 o'clock a.m., Resident #1's family member reported the resident had been picking at locks and poking at the key pad. The resident wants to go home and will continue to try. During an interview on 8/1/2017 at 11:50 a.m. Staff A, RN (Registered Nurse)/DON (Director of Nursing), reported on Sunday, July 30 at approximately 12:30 - 12:40 p.m., Resident #1 exited the facility and walked to the Fareway grocery store. The DON stated the door alarm went off and an unknown staff said they had checked the door and did not see anyone. On 7/30/2017, Staff E, CNA (Certified Nurse Aide), Staff F, CNA and Staff G, CNA were in the unit. Staff E had been on break and Staff F and G served lunch trays. Staff C, LPN, assigned to the unit sat at the SV nurse's station at the time of the elopement. When staff noticed the missing resident, Staff C called a Code Green. Staff checked rooms and Staff E got in the car, found the resident and returned to the facility at 1:11 p.m. The resident easily redirected and had no injury when assessed. The resident had one prior attempt on 6/17/2017	F 323		

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F 323	Continued From page 6 when he/she exited the patio door, but the door alarm sounded and staff retrieved the resident. The DON stated they changed the code to the door after this incident (6/17/17). During an interview on 8/1/2017 at 2:50 p.m., Staff D, RN reported working on 7/30/2017 from 6 o'clock a.m. until 6:30 o'clock p.m.Staff D worked on the WW (Wendt Willows) wing. At 1:00 o'clock p.m. Staff D went into the break room and at 1:05 p.m. someone paged Code Green. Prior to that, while on the phone at the WW nurse's station, Staff D heard a door alarm and the notification board at the nurse's station identified it as the patio door. Somebody yelled "all clear" and Staff D canceled the alarm. When they noticed the missing resident [when passing lunch trays], Staff E, CNA got in the car, found the resident and returned at 1:15 p.m. Staff D assisted the resident out of the car. The resident had no injury and appeared fine. Resident #1 is smart and will stand near the exit doors in the unit and watch people. During an interview on 8/2/2017 at 1:30 p.m., Staff C, LPN reported working on 7/30/2017 at 6 o'clock a.m. until 6:30 p.m. on the SV (Sunshine Valley) and SVS (Sunshine Valley Suites/dementia unit). Staff C indicated at breakfast Resident #1 had a bag on his/her walker. At 10:00 a.m. the CNA's in the unit reported the resident pushed the keys on the door alarm and had figured out the code to the shower room door alarm. When Staff C observed the resident between 10:00 and 11:00 a.m., the resident sat in the room in the recliner talking to family. Staff C reported he/she never reported it to maintenance. At approximately 12:40 - 12:45 p.m., the elopement occurred. Staff C called	F 323		

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F 323	Continued From page 7	F 323		

maintenance to change the unit exit door alarm codes. When staff reported they failed to locate Resident #1, Staff C called a Code Green after checking the unit. Staff E, CNA brought the resident back to the facility and Staff C assessed the resident. The resident indicated he/she planned to go home. The resident's family verified the resident had been on the right path. Staff C never heard the alarms sound. Staff C returned from break around 12:30 p.m.
Staff inside the break room, cannot hear the door alarms except for the one near the employee exit. Staff also cannot hear the alarm panel while inside the break room. Resident #1 ambulated independently with a walker. Staff C never witnessed the resident with exit seeking behaviors. Staff C revealed he/she should have called maintenance to change the codes when staff reported the resident knew the code at 10:00 a.m. Staff C underestimated the resident's ability.

During an interview on 8/2/2017 at 9:30 a.m., Staff F, CNA, CMA (Medication Aide) reported working on 7/30/2017 from 6 a.m. until 2:30 p.m. in the dementia unit. Around 10 o'clock a.m. Staff F observed Resident #1 enter the alarm code on the shower room door key pad. The resident had figured out the code and said he/she wanted to go to exercise. Staff F reported it to Staff C, LPN immediately. Staff C indicated since it was a weekend, they needed to call the on call maintenance person and hopefully the resident would forget the code. Staff F told Staff C the resident would not forget the code. Staff F directed the other staff to keep eyes on the resident. Staff F went to lunch break at 10:50 a.m. until 11:20 a.m. and had observed the resident in his/her recliner. Staff G went to lunch at approximately 11:25 - 11:55 a.m. and Staff E at

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F 323	Continued From page 8 approximately 12:05 until 12:35 p m. Staff F started passing medication and assisted Staff G in getting residents to the dining room table. Resident #1 was awake and seated in the recliner when Staff F went to assist a resident to the bathroom and the table. Staff G assisted residents with their clothing protectors and served coffee. Staff F never saw Resident #1 in the dining room, and assumed he/she would be coming. Dietary staff arrived and they passed lunch trays. When they failed to see the resident in the dining room or the bedroom, they checked therapy and notified Staff C. Staff did a room to room search as well as the parking lot and exits. Around 12:45 - 1:00 p.m. Staff C called a Code Green. Staff E returned from break and looked for the resident by car. When Staff E returned with the resident, the walker had the Roam Alert/Wanderguard bracelet intact. The resident must have exited through the shower room door, walked into the hall and out the patio door. The alarms or pages are not heard inside the unit. They assumed the resident exited through the East Patio door, down the side walk to Hillcrest road and crossed over towards Fareway where Staff E found him/her. Approximately 20 minutes had passed from the time they noticed the missing resident until he/she returned. They added motion detectors and 15 minute checks. During an interview on 8/1/2017 at 2:10 p.m., Staff G, CNA reported working in the dementia until on 7/30/2017 from 6:00 a.m. until 2:30 p.m. Staff G took lunch break from 11:25 - 11:55 a.m. Dietary brought food carts at approximately 12:20 p.m. Staff G observed Resident #1 when he/she notified the resident of lunch. The resident sat in the bedroom working on a puzzle. The resident came out and sat at a table using the walker. 10	F 323		

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F 323	Continued From page 9 minutes had passed and they went to pass Resident #1's tray and failed to find him/her. Staff G checked all resident rooms, notified the nurse and called a Code Green. Staff E got in the car and located the resident. When the resident returned he/she said "hello", sat down and ate lunch and appeared fine. Nobody saw the resident leave the unit and they failed to hear the alarm. Only the fire alarm can be heard inside the unit. The resident often stood at the exit door alarm key pads and punched numbers. When the resident first admitted they had to change the code because he/she figured it out and got the door open. During an interview on 8/2/2017 at 2:35 p.m., Staff E, CNA reported working on 7/30/2017 at 6 a.m. - 2:30 p.m. During the day, Resident #1 sat on a chair in the unit between the main exit and the shower room exit and watched people. Earlier that morning, the resident went to the shower room key pad and punched in the numbers. Staff re-directed the resident and Staff F informed the nurse. The resident went to the bedroom and stayed there. When Staff E went to lunch at 12:10 p.m., the resident remained in the bedroom. At approximately 12:40 p.m., Staff E left the break room and heard the Code Green called. Staff E looked through rooms and then went by car. Staff E found the resident between Fareway and Dollar General, and returned with the resident at 1:11 p.m. The resident indicated he/she was going home. During an interview on 8/2/2017 at 11 o'clock a.m., Staff H, CNA / CMA reported working on BV (Bluff View) from 6:00 a.m. until 2:30 p.m Around 12:55 p.m., Staff H passed medication and heart	F 323		

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F 323	Continued From page 10 the SVS patio door and WW #14 door alarm sound. Staff H checked the WW exit door and observed the STOP sign still intact. Staff H went to the WW nurse's station and informed Staff D, RN that there were two door alarms going off. Staff D informed Staff H that he/she was on the phone, silenced the alarms and said "nobody gave me the okay to turn them off". Staff H told Staff D that was because nobody had checked either door. Staff H started down SV hall and ran into Staff I, CNA. Staff H told Staff I to go and check the SVS patio door. Staff H returned to WW and looked out the windows. Staff F, CNA came up from the unit and said they could not find Resident #1. Staff D walked up from lunch and Staff H informed Staff D that one of the residents got out and he/she turned off the alarms. Staff H heard the Code Green and went outside to search for the missing resident. Staff E, CNA returned with the resident. Staff I later admitted to not checking the SVS patio door. During an interview on 8/2/2017 at 8:50 a.m., Staff J, Dietary reported working 7/30/2017. At approximately 12:20 p.m. dietary staff went to the dementia unit with lunch food carts. Dietary staff filled the trays and unit staff passed them. Staff J never saw Resident #1. When dietary staff finished filling trays, they left the unit, and noticed staff were looking for Resident #1. Staff J went on break and heard the Code Green called. During an interview on 8/2/2017 at 8:20 a.m., Staff K, Dietary reported working on 7/30/2017. Around 12:20 p.m. Staff K and Staff J went to the unit with the steam cart and plated food. Staff K never saw Resident #1. They left with the steam cart through the main doors between 12:35 and 12:40 p.m. Staff K never heard door alarms while	F 323		

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F 323	Continued From page 11 in the unit. When they were leaving unit, staff were looking for Resident #1. Kitchen staff cannot always hear the Code Green if the dish machine is running. Staff K never heard the Code Green called. During an interview on 8/2/2017 at 10:40 a.m., Staff L, Maintenance reported he/she received a call from the facility at 1:42 p.m. on 7/30/2017. Staff L reported to the facility and changed the unit shower room/exit code. They added motion detectors and recently locked the shower room door where only staff has a key. The facility is looking at a key fob system for exit doors. Staff C, LPN and Staff D, RN received an Employee Warning violation for creating or contributing to unsafe working conditions related to Resident #1's elopement. The facility Elopement, Risk Prevention and Management of Missing Resident Policy effective 6/1/2014 included: Policy: The facility strives to promote resident safety and protect the rights and dignity of the residents. The facility maintains a process to assess all residents for risk for elopement, implement prevention strategies for those identified as an elopement risk, institute measures for resident identification at the time of admission and conduct a missing resident procedure. Procedure: Assessment - An elopement risk assessment is completed by nursing staff on admission, quarterly and upon change of condition. Prevention: 1. Interventions that may be used for residents identified as high risk for elopement include:	F 323		

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F 323	Continued From page 12 a. Designate resident as an elopement risk. b. Place a Wanderguard bracelet on c. Place a profile sheet indicating diversion activities d. Include activities that are in full view of staff e. Notify staff of residents at risk f. Develop an elopement care plan g. Update family h. Review weekly by Care Plan team i. Transfer to a secure CCDI unit 2. Verification of control systems. a. Each resident Wanderguard bracelet is checked twice daily and functioning is documented on the MAR (Medication Administration Record). b. Wanderguard door mechanisms are checked weekly. c. Door alarms are checked daily d. Wanderguard door alarm codes are changed as needed e. Key pad door alerts in CCDI unit are changed as needed. f. A sign in/out sheet is in place that requires responsible parties to sign the resident out when leaving. 3. Prevention strategies are listed on each resident's care plan and reviewed quarterly or with a change in condition. C. Intervention 1. Responding to an actual elopement a. All staff respond to active door alarms and return resident to their unit b. If a door alarm sounds and staff cannot determine who alarmed the door, an accountability of all residents will be completed. c. Any resident who leaves the facility should be approached according to acceptable guidelines. d. Diversion activities encouraged to prevent recurrence.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165513	A. BUILDING _____ B. WING _____	C 08/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 13 e. Family and physician notified of the incident. f. Safety checks are documented while on increased supervision. g. Incident is reported to state authorities by Administrator or designee. 2. When a resident is determined missing. a. Note the time b. Assign staff to units c. Notify Administrator and Director of Nursing d. Staff will conduct a thorough search of the facility to locate the resident. If the resident has not been found, notify the police. 3. When the resident has been found: a. Examine for injuries, notify physician, update care plan, complete form and notify state authorities. The facility abated the IJ on 7/30/17 when they re-educated staff on the elopement prevention and code green policy. Staff not present were educated on 7/31/17. In addition on 7/30/17 -7/31/17 the facility also added elopement interventions that included the following : Resident #1 was placed on 15 minute checks; CCDI (unit) door codes changed by maintenance. The facility planned to add motion sensors to tub room and back stairway; Global Com came to research use of fob/card reader system for CCDI doors. In addition, the facility planned for the CCDI hallway patio doors secured East side locked and push bar removed. Motion sensors added to West side; CCDI shower door locked.	F 323		