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 12/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 12/4/17-507 The following deficiencies were identified during the investigation of complaint #71005, #72415, #72734 & #72849. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C). Complaint #71742 was not substantiated. The IJ pertaining to the elopement at F689 was corrected on December 4, 2017, therefore it is a past non-compliance IJ.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to provide adequate supervision to Resident #4 to ensure against hazards from self or elements in the environment when wandered outside the secured memory care unit into the adjoining courtyard, unnoticed by staff. This placed an immediate jeopardy to the health and security of the resident. On 12/4/17 the facility had adjusted the door to ensure closure, added an additional door alarm to alert staff and provided an inservice to staff about the emergency door use. The facility reported a	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/28/2017

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 689	Continued From page 1 census of 78 residents and the sample consisted of 7 residents. Findings including: 1. According to the Care Plan, Resident #4 entered the facility on 11/13/13 and had diagnoses which included acute embolism/thrombus (blood clot) of the lower extremity, Parkinson's disease (neurological disorder), anxiety, depression, high blood pressure and dementia. Resident #4 had a Minimum Data Set (MDS) assessment with a reference date of 9/11/17. The MDS indicated Resident #4 was unable to complete the brief interview for mental status (BIMS) and had a problem with long term and short term memory problems and a severe impairment of cognition for decision making skills. The MDS assessment described Resident #4 as requiring extensive staff assistance with activities of daily living, including bed mobility, dressing, eating, toilet use and personal hygiene and bathing. Resident #4 was able to transfer and ambulate in the memory care unit with staff supervision. The Care Plan identified Resident #4 as able to transfer self and ambulate as desired in the memory care unit without an assistive device. The Care Plan identified the resident to be an elopement risk due to impaired safety awareness and a history of attempts to leave the facility unattended on 10/30/14. The interventions/tasks directed staff to implement the following: Disguise exits; exit doors with murals,	F 689		

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F 689	Continued From page 2 Distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and book(s), Do not argue or get in her face, give the resident space, Keep traffic to a minimum; in and out of the memory care unit, The resident moved to the secured (locked) unit on 3/27/14, Do not block interior doors, Speak in a calm voice, Use courtyard if other areas are not successful. According to documentation in the Nurse's Notes dated 12/2/17 at 5:45 p.m., a nurse entered the memory care unit and stated Resident # 4 was observed sitting on the ground inside the locked courtyard area. Resident #4 was seated on her buttocks with her back against the building. The nurse assisted Resident #4 back into the building. According to the facility incident report Resident #4 walked into the building without difficulty. The report indicated Resident #4's hands were cold to touch and an assessment identified an abrasion to Resident #4's right shoulder blade, measuring 6 centimeters (cm) by 2.5 cm and a skin tear to Resident #4's left side rear scalp measured 1.3 cm by 0.3 cm with a scant amount of blood. The notation indicated staff applied an ice pack to the area, checked vital signs (temperature 96.6 (normal 98.6), pulse 79 (normal 60-100), blood pressure 145/67 and respirations 20 (normal 16-20). The nurse initiated neuro (neurological) checks as per facility protocol.	F 689		

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F 689	Continued From page 3	F 689		

On 12/12/17 at 2:09 p.m. Staff A (certified medical assistant) was interviewed and stated on the afternoon shift of 12/2/17, she heard Staff B state to Staff C that she (Staff B) was going on her thirty minute break. Staff A stated she observed Staff B go to the emergency door and exited the memory care unit. Staff A stated she had observed other staff using the emergency door to exit the memory care unit.

Staff A stated she recalled during her orientation to the facility she was aware that certain doors were marked for "emergency exit" while other (secured) doors were for staff to routinely use utilizing their key fobs.

On the afternoon of 12/2/17, Staff A described Resident #4 as in a good mood and constantly wandering into other resident rooms. Staff A stated Resident #4 would go towards and stand by an exit door, but did not push on the door, nor did Resident #4 activate the door alarm.

Staff A stated she was unaware that Resident #4 had exited the memory care unit until staff accompanied Resident #4 back into the unit. Staff A stated no alarms had sounded indicating a door had been opened.

Staff A stated when Resident #4 returned inside the unit she assisted the nurse to complete a physical assessment. Staff A stated Resident #4's fingers and hands were cold, and her gait per usual. Staff A stated blankets were put around Resident A, but she tossed them off.

On 12/12/17 at 4:41 p.m. Staff C (certified nursing assistant) was interviewed and stated she worked in the memory care unit the evening of

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F 689	Continued From page 4 12/02/17. Staff C described Resident #4 as a wanderer, going into other resident rooms, and at times tried to follow staff from one unit to the next. Staff C stated on the evening of 12/2/17 (at about 4:45 p.m.), Staff B exited the memory care unit through the emergency door. Staff B returned about 6:30 p.m. Staff C stated she was unaware that Resident #4 had exited the building as she was getting residents ready for the evening meal and figured Resident #4 was in another resident room. On 12/13/17 at 7:46 a.m. Staff B (certified nursing assistant) was interviewed and stated she exited the memory care unit at about 4:40 p.m. on 12/2/17. Staff B stated she was not aware that Resident #4 was near her when she left the building. Staff B stated she was unaware that the door did not latch. She stated she went through the door and thought the door would shut. On 12/12/17 at 4:28 p.m. Staff D (licensed practical nurse) was interviewed and stated she became aware that Resident #4 had exited the memory care unit when another staff member brought Resident #4 back into the unit. Staff D stated she was unaware that Staff B had left the unit for a break. Staff D stated she did not know how Resident #4 could exit the memory care unit, other than to follow someone out. She stated the only exit in the memory care unit is the emergency exit and it is not to be used (routinely). On 12/12/17 at 2:49 p.m. (licensed practical nurse), was interviewed and stated she left the facility on the evening of 12-02-2017 through the east, back employee door. Staff E stated as she headed toward her car, she heard something but didn't see anything. Staff E stated she went to the	F 689		

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F 689	Continued From page 5	F 689		

enclosed courtyard and saw Resident #4 sitting on the ground. Staff E stated she covered Resident #4 with her own coat and ran back inside the facility to get help.

On 12/12/17 at 9:00 a.m. the State Climatologist was contacted and stated the weather on 12/02/17, at the airport (nearest to the facility) at 5:18 p.m. was 37 degrees Fahrenheit. The winds were calm and the sky was clear.

On 12/11/2017 at 3:51 p.m. the facility Administrator and Director of Nursing (DON) was interviewed and stated they had completed an investigation of this event. According to their interview as well as a written summary of the event, Staff B exited the memory care unit on 12/02/17 at approximately 4:40 p.m. Initially it was assumed Resident #4 followed Staff B out the door at that time. According to camera review, it was noted Resident #4 exited the memory care unit at 1710 (5:10 p.m.). Via the video camera staff could observe Resident #4 walked around the sidewalk within the courtyard. Resident #4 sat on the chairs and a bench in the courtyard. The resident's gait was steady and even. Resident #4 did not show any signs of distress, nor did she attempt to exit the gate on the opposite side of the courtyard. At 5:36 p.m. Staff E noticed Resident #4 sitting on the ground next to the building at which time Resident #4 started to get up, and Staff E assisted Resident #4 back into the building. The Administrator and Director of Nursing stated the resident wore gray pants, long sleeved sweater, socks and gripper socks. The resident did not have a coat, shoes or gloves.

On 12/4/17, the facility had corrected the immediate jeopardy situation. The maintenance

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F 689	Continued From page 6 employee adjusted the door tension to ensure closure of the door and a back up alarm was added to the door. The staff received an inservice on 12/4/17 about the emergency door and staff are not to use the door unless in the event of an emergency.	F 689		

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 104 SS=D	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 interview, the facility failed to report an elopement to the Department of Inspections and Appeals as required for 1 resident that exited the facility without staff knowledge. (Resident #4) Findings include: The current Care Plan identified Resident #4 had an admission date into the facility on 11/13/13. The Care Plan identified the resident had diagnoses that included acute embolism/thrombus (blood clot in an artery) of the lower extremity, Parkinson's disease (neurological disorder), anxiety and dementia. Resident #4 had a Minimum Data Set (MDS) assessment with a reference date of 9/11/17. The MDS indicated Resident #4 was unable to complete the brief interview for mental status (BIMS) and had a problem with long term and short term memory problems and a severe	N 104	Administration will notify the director of DIA or the director's designee within 24 hours, or the next business day by the most expeditious means available when a resident elopes from a facility and as required under Chapter 50.7(4) 481-507.7 (10A,135C). Administrator(s) and Director of Nursing were re-educated on this requirement and evidence of the re-education was signed and filed in their personnel files on	Dec. 14, 2017

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael B. Davis, LNHA	Administrator	12/28/17

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 104	Continued From page 1 impairment of cognition for decision making skills. The MDS assessment described Resident #4 as requiring extensive staff assistance with activities of daily living, including bed mobility, dressing, eating, toilet use and personal hygiene and bathing. Resident #4 was able to transfer and ambulate in the memory care unit with staff supervision. The Care Plan identified the resident to be an elopement risk due to impaired safety awareness and a history of attempts to leave the facility unattended on 10/30/14. The interventions/tasks directed staff to implement the following: Disguise exits; exit doors with murals, Distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and book(s), Do not argue or get in her face, give the resident space, Keep traffic to a minimum; in and out of the memory care unit, The resident moved to the secured (locked) unit on 3/27/14, Do not block interior doors, Speak in a calm voice, Use courtyard if other areas are not successful. The Nurse's Notes dated 12/2/17 at 5:45 p.m., documented a nurse entered the memory care unit and stated the resident was observed sitting on the ground inside the locked courtyard area. The resident was seated on her buttocks with her back against the building. The nurse assisted the resident back into the building.	N 104		

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N 104	Continued From page 2 The facility incident report documented the resident walked into the building without difficulty. The resident's hands were cold to touch and an assessment revealed an abrasion to the resident's right shoulder blade measuring 6 centimeters (cm) by 2.5 cm and a skin tear to the residents left side rear the scalp measuring 1.3 cm by 0.3 cm with a scant amount of blood. The notation indicated staff applied an ice pack to the area, checked vital signs and initiated neuro (neurological) checks as per facility protocol. On 12/12/17 at 4:41 p.m. Staff C (certified nursing assistant) was interviewed and stated she worked in the memory care unit the evening of 12/02/17. Staff C described Resident #4 as a wanderer, going into other resident rooms, and at times tried to follow staff from one unit to the next. Staff C stated on the evening of 12/2/17 (at about 4:45 p.m.), Staff B exited the memory care unit through the emergency door. Staff B returned about 6:30 p.m. Staff C stated she was unaware that Resident #4 had exited the building as she was getting residents ready for the evening meal and figured Resident #4 was in another resident room. On 12/13/17 at 7:46 a.m. Staff B (certified nursing assistant) was interviewed and stated she exited the memory care unit at about 4:40 p.m. on 12/2/17. Staff B stated she was not aware that Resident #4 was near her when she left the building. Staff B stated she was unaware that the door did not latch. She stated she went through the door and thought the door would shut. During interview on 12/11/17 at 3:51 p.m., the Administrator and Director of Nursing stated they completed an investigation of the event and according to the interviews as well as the written	N 104		

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 104	Continued From page 3 summary of the events, Resident #4 exited the memory care unit at 5:10 p.m. per the video camera. At 5:36 p.m., Staff noticed the resident sitting on the ground next to the building at which time the resident started to get up, and staff assisted the resident back into the building. The facility determined the resident was in the enclosed courtyard for a short period of time, not near any danger and the weather was beautiful and the resident was appropriately dressed and there was no major injury therefore the incident was not reported. The Administrator and Director of Nursing stated the resident wore gray pants, long sleeved sweater, socks and gripper socks. The resident did not have a coat, shoes or gloves. On 12/12/17 at 9:00 a.m. the State Climatologist was contacted and stated the weather on 12/02/17, at the airport (nearest to the facility) at 5:18 p.m. was 37 degrees Fahrenheit. The winds were calm and the sky was clear.	N 104		