

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: FC 6762					Date: February 16, 2018
Facility Name: United Presbyterian Home		Survey Dates: January 18-26, 2018			
Facility Address/City/State/Zip 1203 East Washington Street Washington, IA 52353					
		HL			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date	

135C.44	135C.44 Treble fines for repeated violations. The penalties authorized by section 135C.36 shall be trebled for a second or subsequent class I or class II violation occurring within any twelve-month period if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor. <small>[C77, 79, 81, §135C.44]</small>			
56.6(1)	56.6(1) Treble fines for repeated violations. The director of the department of inspections and appeals shall treble the penalties specified in rule 481—56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor.			
58.28(3)e	481- 58.28(3) Resident safety. e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) DESCRIPTION: Based on record review, observations and interviews, the facility failed to provide adequate supervision to			
		I	\$19,500.00 Treble Fine (\$6500.X3 Held in Suspension	Upon Receipt

Facility Administrator

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	<p>prevent 2 residents from elopement. The facility did not implement safety provisions to address two (2) exit doors. Resident #1 eloped from the front door of the facility without staff's knowledge on 12/2/17. The facility staff were not aware Resident #1 had been outside for 7-10 minutes; with a nearby highway approximately 70 feet away.</p> <p>The facility had 4 independently mobile and cognitively impaired residents putting other residents at risk. The facility failed to ensure an audible alarm functioned for Resident #2. Resident #2 Wanderguard's system did not alarm when she exited the nursing home and staff did not know she had been in the independent living section of the building. The facility reported a census of 50 residents.</p> <p>Findings Include:</p> <p>1. The Independently Mobile and Cognitively Impaired resident list received on 1/25/18 revealed the facility had 4 residents independently mobile and cognitively impaired.</p> <p>a. According to the Admission Record dated 1/18/18 Resident #1 had diagnoses of repeated falls, traumatic subarachnoid hemorrhage and Parkinson's Disease.</p> <p>The Minimum Data Set (MDS) assessment dated 9/27/17 revealed Resident #1 had moderate cognitive impairments and no wandering behaviors.</p>			
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	<p>The Wandering Risk Assessment dated 9/27/17 revealed Resident #1 had no known wandering or history of wandering, no elopement attempts. The resident required stand by assist with a gait belt and front wheel walker.</p> <p>The Plan of Care revised on 9/27/17 directed the staff to provide contact guard assist of one with ambulation with a walker and pull tab alarm while in bed and chair to alert staff when needs assistance.</p> <p>The Progress Notes dated 12/2/17 at 6:10 p.m. revealed a visitor found Resident #1 wandering in the parking lot between the overhang and parked cars. Staff A assisted Resident #1 inside. Resident #1 had clothing on but no coat. The entry revealed it was 50 degrees Fahrenheit outside. The staff informed the Director of Nurses.</p> <p>The Late Entry dated 12/2/17 at 6:10 p.m. revealed Staff A alerted a person outside walking in the parking lot with a walker. Staff A (Licensed Practical Nurse) approached the person and noted it was Resident #1. Staff A located Resident #1 directly north of the awning, in the parking lot, to the south of the vehicles. Staff A escorted Resident #1 back inside. Resident #1 reported he/she was going home. Staff A notified Staff B (Nurse in Charge) of what happened.</p> <p>The Late Entry dated 12/2/17 at 6:45 p.m. revealed Staff B notified Staff C (Maintenance) of what</p>			
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	<p>happened and a Wanderguard placed on Resident #1 at 6:45 p.m. to prevent from leaving the facility.</p> <p>The Late Entry dated 12/2/17 at 7:00 p.m. revealed Staff B completed an assessment of Resident #1 with no abnormal findings. Resident #1 reported he/she just wanted to go home.</p> <p>The Late Entry dated 12/2/17 at 10:40 p.m. revealed Staff B notified the Physician of Resident #1 wandering in the parking lot for 10 minutes and requested an order for a Wanderguard device.</p> <p>The facility investigation revealed on 12/2/17 at approximately 5:50 p.m., Resident #1 had been assisted to a chair by the nurse's station; and by 6:05 p.m., a family visitor informed staff Resident #1 was outside by the north front door approximately 50 feet. Resident #1 reported she was going home (when staff brought her back inside). Resident #1 had been fully dressed and wearing shoes. The staff contacted the maintenance staff. Resident #1's Elpas bracelet was replaced with a bracelet that would [now] alarm and lock exit doors and the facility reported the system was working correctly, in that the north exit was approached by any resident and it sent an alert to the central monitoring system; however the facility identified the message alerts were not being sent to the pagers of staff CNAs.</p> <p>The facility reported due to Resident #1's assessment the facility had only received an Elpas watch which</p>			
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	<p>would not secure the doors but rather ring to staff pagers. On 12/4/17 the facility documented they had problems with the "dead zones" and notification didn't always ring to the staff pagers and they had addressed the issued multiple times in the past. The facility identified the original company currently no longer active had not properly wired the facility. The facility documented Resident #1 did not try to exit seek, there was no reason to anticipate this incident.</p> <p>An onsite observation showed 25 steps from the front door to the other side of the awing; and 67 steps to the sidewalk; 70 steps to the street. The facility is located nearby a heavily traveled 4 lane highway (Highway 92).</p> <p>An interview on 1/24/18 at 12:44 p.m. Staff D (Nurse Aide) reported he/she assisted Resident #1 from the dining room to a chair near the Nurse's Station. Staff D reported he/she left Resident #1 in the chair without the chair alarm. Staff D reported he/she knew Resident #1 had a chair alarm. Staff D reported Resident #1 did not have the alarm at the dining room table. Staff D reported he/she did not go look for the alarm.</p> <p>An interview on 1/24/18 at 10:00 a.m. Staff B reported he/she arrived to work at 5:50 p.m. and received report. Staff B reported Staff A informed him/her that Resident #1 was found outside. Staff A asked Staff B why the door alarm did not sound. Staff B told Staff A</p>			
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	<p>that Resident #1 did not have a Wanderguard device. Staff B reported he/she went to look for the chair alarm and found it tucked in the cushions of the recliner in Resident #1's room.</p> <p>The Facility Investigation (Social Worker) notes revealed Staff D assisted Resident #1 to sit in a chair by the Nurse's Station around 5:50 p.m. At 6:05 p.m., a visitor informed Staff A that Resident #1 was outside the front door 50 feet away.</p> <p>An interview on 1/24/18 at 3:38 p.m. the Director of Nurses reported Staff D received education for leaving Resident #1 in the chair without an alarm.</p> <p>Resident #1's Plan of Care Updated 12/2/17 revealed the facility added a Wanderguard watch to alert staff if she attempted to leave without assistance.</p> <p>b. Observation on 1/24/18 at 3:58 p.m. revealed when exiting/entering the Front Door of the facility no alarm sounded. When approaching the front door with a Wanderguard device the front door locked down with a 15 second egress delay.</p> <p>An interview on 1/24/18 at 12:28 p.m. the Administrator reported the AL Ramp door and the Front Entrance door do not alarm unless the resident has a Wanderguard device in place to activate the alarm.</p>			
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	<p>2. The Residents with Wanderguard list received on 1/25/18 revealed the facility had 10 residents with Wanderguard devices.</p> <p>a. According to the Admission Record dated 1/18/18, Resident #2 had a diagnosis of dementia.</p> <p>The Minimum Data Set (MDS) assessment dated 11/15/17 revealed Resident #2 had severe cognitive impairments. The MDS revealed Resident #2 had wandering behaviors. The MDS revealed Resident #2 required supervision with locomotion.</p> <p>The Wander Risk Assessment dated 11/15/17 revealed Resident #2 had forgetfulness, short attention span and early dementia. The assessment revealed Resident #2 a low risk for wandering.</p> <p>The Plan of Care dated 6/8/17 revealed Resident #2 had a wireless monitoring watch to alert staff if Resident #2 exited the facility and to ensure someone accompanies Resident #2 out of the facility. The monitoring watch would lock the door when Resident #2 got close to the door and staff would ensure Resident #2 did not leave unattended. Resident #2 walks (ambulates) by herself and was able to transfer herself without an assistive device.</p> <p>The Progress Notes dated 12/26/17 at 3:55 p.m. revealed the staff received a call from an Independent Living tenant reporting Resident #2 was in the</p>			
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	<p>Independent Living unit. The Elpas system recorded Resident #2 at the AL ramp at 3:24 p.m. The staff went to the Independent Living Unit and assisted Resident #2 back to the nursing facility. The staff assessed Resident #2 and found no abnormalities. The staff notified the family who reported they visited earlier and left Resident #2 resting in bed when they left.</p> <p>The Progress Notes dated 12/26/17 at 5:54 p.m. revealed an Independent Living tenant leaving the nursing facility (AL ramp door) reported there was a man who exited the door at the same time as the Independent Living tenant. The Independent Living tenant did not see Resident #2. However, the Independent Living tenant felt that someone was behind him/her.</p> <p>The facility investigation of the incident revealed, an Independent Living tenant asked Resident #2 to accompany her back to the nursing facility on 12/26/17; and Resident #2 did not verbalize an acknowledgment of where she was or where she was going. Upon returning to the nursing home, Resident #2's nurse approached them. Resident #2 had been dressed and wearing a pair of slacks, long sleeve shirt with sweater, and non-skid shoes. Resident #2's had a history of being a frequently walker and her family reported prior to her admission, she would leave her apartment for a walk and had difficulty locating the correct entrance and directions to get back to her</p>			
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	<p>apartment. The facility noted staff were made aware of Resident #2's was by the East door per the Elpas pagers, but the audible alarm did not sound and they were unaware that she had exited the building [nursing building]. The Maintenance staff member may have disabled the audible alarm to the east door when they upgraded the system in September [2017].</p> <p>An interview on 1/19/18 at 12:22 p.m. revealed the Director of Nurses (DON) reported she completed some of the nursing daily door checks. The DON reported she checked the AL Ramp door with a Wanderguard watch. The DON checked to ensure the door locked down when approached. The DON reported she did not push the handicap accessible button to open the door and then walk through the door with the Wanderguard watch to test the audible alarm. The DON reported the facility had a new server installed. When the server was installed the AL Ramp door audible alarm was not programmed into the new server. The audible alarm did not function when Resident #2 went through the AL Ramp door. When a resident goes through the door an audible alarm sounds and a page goes out to the staff that the resident exited the facility. The DON reported the AL Door and the Front door are both alarmed in the same manner. The DON and Maintenance are the only staff authorized to reset the AL Ramp door and the Front Entrance alarm. The DON reported she provided in-service training after Resident #2's elopement on how to properly complete the daily door checks.</p>			
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	<p>An interview on 1/19/18 at 9:38 a.m. Staff C (Maintenance) reported on 12/27/17 he/she programmed the AL Ramp door audible alarm in the server. Staff C reported the facility hired a company to install the new server. The new server was installed 9/19/17 to 9/22/17. Staff C reported Staff were alerted she was by the door but did not think Resident #2 went through the door.</p> <p>The Alerts Results reported on 12/26/17 at 3:46 p.m. revealed the staff received an alert Resident #2 at the AL Ramp for 14 seconds. An alert was sent to staff again at 3:58 p.m. for the AL Ramp door.</p> <p>The facility Elpas Nurse Call & Elopement Management system documented each resident wears a pendant and the pendant serves three main purposes - call button for assistance, real-time location and Wanderguard. The facility identified their building is equipped throughout with a variety of readers which can tell where a resident is located anywhere in the premises. The elopement management piece of Elpas for residents with a propensity to wander, a locking wrist band is provided and can only be removed with a special key. When they move into the field of a door reader, the door locks and will not unlock until they leave the door reader's field or after holding the door for 15 seconds. If the resident holds the door for 15 seconds or if they move into the door reader's field when the door is open, a message is sent to the staff</p>			
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	<p>handheld devices and staff computers and an alarm will sound alerting staff that the resident is at an open door.</p> <p>On 1/24/18 at 4:33 p.m., the Administrator reviewed the door alarms and reported all door will alarm except for the front door and door to the Independent Living area. The Administrator reported the front doors have 2 Radio Shack magnetic alarms and obtained a key to turn the alarms On. The Administrator then left these alarms turned On and called the maintenance to see what could be placed on the Independent Living door and reported she would have staff stationed by the door to watch for exiting residents. After 10 p.m., the Administrator reported she would then turn back On the Radio Shack alarms and will call the company to see what can be done.</p> <p>FACILTY RESPONSE:</p>			
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