

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

PRINTED: 02/16/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165482	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/26/2018
NAME OF PROVIDER OR SUPPLIER  UNITED PRESBYTERIAN HOME		STREET ADDRESS, CITY, STATE, ZIP CODE  1203 EAST WASHINGTON STREET WASHINGTON, IA 52353		
(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 <u>02/26/2018</u>  The following information relates to the investigation of complaint 70605-C and facility reported incidents 72763-I and 73203-I conducted 1/18/18 to 1/26/18. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.  Facility reported incidents 72763-I and 73203-I were substantiated  Complaint 70605-c was substantiated. 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: The following information relates to the investigation on self-report #72763 and #73203.  Based on record review, observations and interviews, the facility failed to provide adequate supervision to prevent 2 residents from elopement. The facility did not implement safety provisions to address two (2) exit doors to ensure the safety of residents placing residents health and safety at an immediate jeopardy. Resident #1 eloped from the front door of the facility without	F 000	F689: 1.) Maintenance reviewed the residents on the server on 12/27/2017 and made sure that 100% of the residents were able to be seen by the Elpas system. 100% compliance was obtained.  2.) As of January 26, 2018 the elopement management piece of Elpas has been set up as follows and staff educated: -For residents with a lower cognitive ability and the propensity to wander, a locking wrist band is provided which 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 handheld devices and staff computers and an audible alarm will sound alerting staff that the resident is at an open door.  -For residents who are not a wander risk, a message is sent to the staff handheld devices and staff computers when they move into a door reader's field. The door will not lock, but if they open the door, a message is sent to the staff handheld devices and staff computers and an audible alarm will sound alerting staff that the resident is at an open door.	12/27/2017  01/26/2018
F 689 SS-K		F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Erin Drahota*

TITLE

*CEO/Administrator*

(X6) DATE

02/16/2018

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	<p>Continued From page 1</p> <p>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.</p> <p>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>Finding 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> <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</p>	F 689	<p>F689 Continued:</p> <p>3.) On February 7, 2018 at the Campus Council Meeting, independent living residents monthly meeting, education was given to the residents about the survey findings, corrections and how to help health center staff ensure that residents stay in the health center and don't follow independent living residents out of the health center.</p> <p>4.) Independent living door that attaches to the nursing home was also looked at by maintenance and G-MAC Doors and Hardware Company on February 13, 2018 and the delay on the door was decreased from 14 seconds to 7 seconds.</p> <p>5.) On February 8, 2018 education during a staff meeting was provided about the survey finding, corrections and Elpas system. On February 22, 2018 during an additional staff meeting nurses were educated on the updated door alarm checklists and how to complete the door alarm checks daily. Review of updated Elopement Policy/Procedure Completed. Nurses were in 100% compliance.</p> <p>6.) As of February 9, 2018 administrators, DON, receptionists and nurses were all authorized in the Elpas system to allow them to be able to reset residents alarms; not just DON and maintenance.</p>	02/07/2018 02/13/2018 02/15/2018 02/22/2018 02/9/2018 and on going

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F 689	<p>Continued From page 2</p> <p>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 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</p>	F 689	<p>F689 Continued:</p> <p>7.) DON and maintenance updated the door alarm check list so that it matched the new door labels (numbers) and each alarm on the doors were color coded. The updated door alarm check list was also updated to require nursing staff and/or maintenance to test the audible alarms. Completed 02/22/2018.</p> <p>8.) Resident Elpas pendants will be checked daily by nursing staff or designee to ensure they are in place on each resident and functioning.</p> <p>9.) Door alarm checks to be completed daily on first shift (6a-2p) by nursing staff and monthly by maintenance staff. Door alarm check sheets by both nursing staff and maintenance will be turned into DON monthly x2 to ensure understanding and compliance then turned in quarterly to DON to take to QAPI meetings to ensure 100% compliance.</p>	02/22/2018  02/26/2018  02/26/2018 and on going

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F 689	<p>Continued From page 3</p> <p>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. The facility reported due to Resident #1's assessment the facility had only received an Elpas watch which 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 awning; 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>	F 689	<p>F689 Continued:</p> <p>10.) Maintenance and DON completed a door alarm check on 2/26/2018 and doors were in 100% compliance. This check was given to DON for the first monthly check that will be reported to QA on 2/28/2018.</p>	02/26/2018

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F 689	<p>Continued From page 4</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 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</p>		F 689		

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F 689	<p>Continued From page 5</p> <p>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> <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</p>	F 689	

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F 689	<p>Continued From page 6</p> <p>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 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, a 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 apartment. The facility noted staff were made aware of Resident #2's was by the East door per</p>	F 689		

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F 689	<p>Continued From page 7</p> <p>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> <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</p>	F 689	

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F 689	<p>Continued From page 8</p> <p>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 &amp; 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.</p> <p>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 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</p>	F 689		

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F 689	<p>Continued From page 9</p> <p>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>On 1/24/18, the facility abated the IJ when they turned On the Radio Shack alarms at the two doors not alarmed and temporarily added a staff to observe residents.</p> <p>On 1/26/18 the facility door management system (Elpas Nurse Call &amp; Elopement Management system) was updated for residents who are not a wander risk, specifically a message is sent to the staff handheld devices and staff computers when they move into a door reader's field. The door will not lock, but if they open the door, a message is sent to the staff handheld devices and staff computers and an alarm will sound alerting staff that the resident is at an open door.</p> <p>Residents are continually monitored for changes in mental status, and if the staff notices a change or an increased propensity to wander, they will be moved into the "wander group" and provided a locking band to ensure they do not remove their pendant.</p> <p>The facility in-serviced staff on 1/24/18 on this new system. These findings lowered the IJ from a "K" severity level to a "E" with ongoing monitoring to ensure residents safety.</p>	F 689		