

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

Citation Number: <b>6812</b>		Date: <b>June 11, 2018</b>		
Facility Name: <b>QHC Winterset North</b>		Survey Dates: <b>May 14-17 &amp; May 21-24, 2018</b>		
Facility Address/City/State/Zip  <b>411 East Lane Street Winterset, Iowa 50273</b>	MW			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

<b>58.28(3)e</b>	<p><b>58.28(3) Resident safety.</b></p> <p>e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)</p> <p><b>DESCRIPTION:</b></p> <p>Based on clinical record review, observations, staff, resident and family interviews and facility policy review, the facility failed to provide supervision to prevent unsafe items in the facility and to prevent elopement (unplanned exit) for one of 16 sampled residents (Resident #1). The facility reported a census of 52 residents.</p> <p>Findings include:</p> <p>1. According to the Minimum Data Set (MDS) assessment dated 2/8/18, Resident #1 admitted to the facility on 10/31/17. The MDS indicated Resident #1 had short and long-term memory problems and modified independence with cognitive skills for daily</p>	I	<b>\$8750 (Held in Suspension)</b>	<b>UPON RECEIPT</b>
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<p>decision-making. The MDS indicated Resident #1 did not exhibit any behavioral symptoms at the time of the assessment. The MDS listed the following diagnoses for Resident #1: hypertension, seizure disorder, depression, uncomplicated alcohol dependence and alcohol dependence with withdrawal. The assessment recorded Resident #1 displayed independence with bed mobility, transfers and walking in his room. The MDS listed Resident #1 used a wander/elopement alarm daily.</p> <p>A. Review of Resident #1's care plan revealed the following focus: Resident #1 had a tendency to have unsafe items on himself and/or in his room. The care plan listed numerous interventions initiated on 2/21/18: Resident #1's family and the resident received a list of unsafe items, his room will be checked for unsafe items as staff feels is necessary, when he returns from outing with family and friends, staff will search his person and room for unsafe items, if items are found on Resident #1 or in his room please explain to him (if present) why they are unsafe and staff must take the items and return them to</p>				

Page 2 of 44

Facility Administrator

Date

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	<p>his family and staff should report all unsafe items to the Administrator immediately. Resident #1's POA (Power of Attorney) agreed to the interventions. On 2/27/18, staff added further interventions which included: Resident #1's person and room will be searched after having any visitors in the building (the POA agreed), staff should communicate with Resident #1 about the need for safety of everyone in the building, communication with Resident #1 and his family regarding these matters will continue to ensure no adverse effects related to policies and procedures being carried out and Social Services would be available to Resident #1 as needed for communication.</p> <p>Observation on 5/16/18 at 10:30 AM revealed Resident #1 out of his room. Staff A, CNA (certified nursing assistant) stated Resident #1 was at Church Service out front with staff. With Staff A present, the surveyor observed the resident's windows while Staff A did a room search.</p> <p>A Social Service Note date 2/27/18 at 1:54 PM documented during an as needed (PRN)</p>			<b>Correction date</b>

Page 3 of 44

Facility Administrator

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	room search in Resident #1's room, staff found a weapon in a coffee storage box. Staff immediately notified the Administrator and seized (ceased) the weapon. Staff notified the local authorities and POA and called a meeting with the following in attendance: Administrator, Director of Nursing (DON), Assistant DON (ADON), Social Services and resident's POA. In the meeting Resident #1's POA agreed to the following terms for Resident #1 to continue to live at the facility: due to the contraband and weapons only being found after outings with the resident's ex-wife, outings with her will now be prohibited. Resident #1's POA may take him out of the building with the understanding that Resident #1 will be searched upon return along with his room. After anyone visits Resident #1 in the facility, Resident #1 and his room will be searched and PRN searches of Resident #1's room as well. At the end of the meeting, the Administrator, DON, ADON, and POA went to Resident #1's room to discuss this with him and do a thorough search of his person and his room with his POA present. Staff updated			

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	<p>the resident's care plan to reflect these changes.</p> <p>Review of progress notes 10/31/17 through 5/15/18 revealed no other progress notes about Resident #1 bringing in any other unsafe items in to the facility. Review of the progress notes revealed a gap of no progress notes from 2/14/18-2/27/18.</p> <p>Review of facility's Release of Responsibility for Leave of Absence sign out and sign out sheet revealed the following:</p> <p>On 2/23/18 at 10:35 AM Resident #1's ex-wife signed him out and returned him to the facility at 8:40 PM.</p> <p>On 3/26/18 at 11:50 AM, his ex-wife and mom signed him out and no sign back in date or time available.</p> <p>On 4/25/18 at 11:25 AM, Resident #1's ex-wife signed him out with a return time of 1:07 PM.</p> <p>On 5/13/18 at 12:45 PM, Resident #1's POA signed him out and returned him to the facility at 2:15 PM.</p> <p>The sign out and sign in sheets recorded Resident #1 still left the facility with his ex-</p>			

Page 5 of 44

Facility Administrator

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	<p>wife, alone after the gun was found in his room.</p> <p>Review of the staffing schedule revealed the following:</p> <p>On 2/23/18 Staff D Licensed Practical Nurse (LPN) and Staff P previous charge nurse worked the 2 PM-10 PM shift.</p> <p>On 3/26/18 Staff S LPN worked the 6 AM-2 PM shift and the ADON, Staff Q previous charge nurse, and Staff D worked the 2 PM-10 PM shift.</p> <p>On 4/25/18 Staff M LPN and Staff S worked the 6 AM-2 PM shift.</p> <p>On 5/13/18 Staff L LPN and Staff D worked the 2 PM-10 PM shift.</p> <p>Review of the spreadsheet labeled Resident #1 room checks sheet revealed the following columns:</p> <p>Date, comments, initials, following-up. The columns had the following entries:</p> <p>2/27/18-door codes with the initials of the Administrator, previous DON, and Social Services</p>			<b>Correction date</b>

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	<p>4/25/18-emptied pockets, empty, nothing of interest in room with the initials of the Administrator</p> <p>5/13/18-returned at 2:15 PM with Staff R Certified Nursing Assistant (CNA) in the follow up section</p> <p>This spreadsheet lacked any information about person and room searches being completed on 2/27/18, 3/26/18 and 5/13/18. This sheet also lacked direction as to what is expected of staff during these searches.</p> <p>During interview on 5/15/18 at 9:08 AM Staff A CNA stated they had previously found a police baton in his room, but did not remember when. Staff A stated Resident #1 brought this from home and that is when they initiated the searches. Staff A stated after Resident #1 goes out with family he was to be checked at the front door by department management. Staff A also stated that during a random room search, she grabbed the trash bag out of the trash can when she bumped a box on the floor. She stated the box seemed heavier than it should, so she looked inside and saw a brown paper bag. She opened the brown paper bag and saw a</p>			<b>Correction date</b>

Page 7 of 44

Facility Administrator

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	<p>loaded .38 millimeter (mm) pistol with an extra clip. Staff A stated she went straight to the Administrator with the gun.</p> <p>On 5/15/18 at 9:40 AM Staff M LPN stated she usually works as the front charge nurse on the 6 AM-2 PM shift. Staff M stated she has not been told what to do when Resident #1 returned from off grounds visits with his family; everything she knows is all hearsay.</p> <p>Staff M stated she heard from the CNAs that management stated Resident #1 is to be searched upon return to the facility but no one has said anything to her about this. Staff M stated she worked when Resident #1 left on Mother's Day (5/13/18) but no one told her what do to when he returned. Staff M stated she asked the Administrator and ADON questions about the gun incident but stated they acted like it was a secret and not to ask questions. Staff M stated she felt as though there should have been a meeting about the loaded gun but there wasn't.</p> <p>During interview on 5/15/18 at 9:58 AM Staff N, the previous Administrator, stated after finding the gun in Resident #1's room, plan-wise nothing was formally put into place.</p>			

Page 8 of 44

Facility Administrator

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	<p>Staff N stated staff would ask Resident #1 if he had anything on him, but does not remember anything in particular that staff were expected to do.</p> <p>During a staff interview on 5/15/18 at 10:14 AM Staff O, the previous DON, stated Resident #1 had dementia due to his alcohol abuse and was at times not oriented. Staff O stated when he first came to the facility his ex-wife and mom would take him out of the facility with no issues. When issues surfaced, the facility did not allow him to go out of the building with his ex-wife because he would bring back items such as a pocket knife, letter opener and a pistol. Staff O stated staff had checked bags when he would come back and that was when they found the knife. Staff was to check his room the next time he left his room for an activity. Staff O stated a CNA could check Resident #1's room without him in there as his POA gave the facility permission to do so. Staff O stated the CNAs on the unit knew this information but they did not do an all staff meeting because they did not want the story to get out of hand. Staff O stated she asked Resident #1 why he</p>			

Page 9 of 44

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	<p>brought the gun to the facility and he stated he just wanted it here and did not plan to hurt himself or others.</p> <p>During interview on 5/15/18 at 10:40 AM Staff Q overnight charge nurse, stated when Resident #1 went off grounds with visitors he should be searched as well as his belongings. She had heard this from other nurses, not from management staff.</p> <p>During interview on 5/15/18 at 2:15 PM Staff I LPN stated she heard from other staff members about the gun in Resident #1's room. After that, staff up front was to do a check on him after he returned from off grounds visits and she thought this was being done before the gun was found. She also stated she never remembered being updated following the gun incident and heard only hearsay.</p> <p>During an interview on 5/15/18 at 2:20 PM Staff J CNA stated he had never been asked to do a room check for Resident #1. Staff J stated he is not sure if it is documented anywhere to complete the checks. Staff J</p>			

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	<p>stated he has never been here when Resident #1 returned from off grounds visits with family and had never been told directly what to do.</p> <p>During interview on 5/15/18 at 4:04 PM Staff K LPN stated she primarily worked at the front of the facility. She had heard no talk about what to do when Resident #1 returned from off grounds visits.</p> <p>On 5/15/18 at 4:08 PM Staff L LPN stated that when Resident #1 left the facility with family, staff were to check his pockets and bags when he returned and he should not leave the facility with his ex-wife. When asked how she knew this, Staff L stated she read it in the nurse's notes and heard it from other nurses. Staff L stated she heard they found a pocket knife prior to the gun but did not know if they were doing checks after that. Staff L stated nurses, the DON, and/or the Administrator were to do the checks after Resident #1 returned.</p> <p>During interview on 5/15/18 at 6:00 PM, Staff U CNA stated she learned of Resident #1</p>			

Page 11 of 44

Facility Administrator

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	<p>having a gun in his room one week after it happened. Staff U stated she heard staff should check Resident #1 when he returned to the facility to see if he had anything on him but she was never asked to do the checks.</p> <p>During interview on 5/16/18 at 7:40 AM, when asked if there were any prior incidences where Resident #1 had brought in any weapons to the facility, the ADON only recalled him bringing in the gun. At 4:10 PM, when asked if the facility had a gun policy, the ADON and Administrator stated it hadn't been approved from the corporate office and they are currently waiting for approval. At 4:15 PM the ADON stated corporate staff would not approve the gun policy because it involved lawyers and such, so no policy had been put in place after Resident #1 brought a gun into the facility. At 4:20 PM, the ADON stated she was unsure why staff updated the resident's care plan on 2/21/18.</p> <p>On 5/16/18 at 9:35 AM, Staff H CNA stated she did not work the day they found the gun in Resident #1's room but heard people were told to keep quiet about it. Staff H stated she</p>			<b>Correction date</b>

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	<p>heard staff should do personal body inspections/checks on Resident #1 when he returned from off ground visits with family. She had never been asked to do the personal checks because he would usually come back after 2 PM and she worked 6 AM-2 PM.</p> <p>During interview of 5/16/18 at 11:25 AM, Staff E Restorative Aide, stated she works either 7 AM-3 PM or 8 AM-4 PM, depending upon where they need her. She works as the restorative aide and fills in on the floor when needed. She stated when she works on the unit it is usually to relieve staff for breaks. On the day the gun was found, she had taken Resident #1 outside for a walk and she learned about the gun via hearsay from other staff members. She stated she had heard staff found a police baton and knives before. Staff D also stated she heard staff should do personal and room checks when he went off grounds but she was never asked to do them.</p> <p>During an interview on 5/16/18 at 12:20 PM, Resident #1's POA stated Resident #1 had brought in knives back in November or December 2017. He also stated that Resident</p>			

Page 13 of 44

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	<p>#1 had always shown an interest in guns and was good friends with his ex-wife. Resident #1's POA stated after they found the gun in his room, he was not allowed to go out on visits with his ex-wife alone but he could go with his mom and ex-wife together. He stated the ex-wife trusted Resident #1 too much. Resident #1's POA stated if he leaves, staff are to search Resident #1 and his room, especially when he leaves with his ex-wife.</p> <p>During interview on 5/16/18 at 1:00 PM, Staff S LPN stated she had never been told about a gun being found in Resident #1's room or directed to do any searches when he returned. Staff S stated she was told only Resident #1's mom is the only one to sign him out for visits and staff then are to go through his room when he is gone. She was told the unit staff did that for their own protection.</p> <p>On 5/16/18 at 1:10 PM Staff A stated, nine residents lived on the CCDI (Chronic Confused and Dementing Illness) unit and eight of those residents could walk independently.</p>			<b>Correction date</b>

Page 14 of 44

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	<p>On 5/16/18 at 1:38 PM, Staff F previous MDS Coordinator stated she found out the Administrator and previous DON had found a hand gun in Resident #1's room and they previously found knives in his room. Staff F stated staff were to check Resident #1 after he went out of the facility and felt this would not get done all the time. Staff F stated Resident #1 would return when no one worked up front, so he would go straight back to his room. Staff F didn't believe all staff knew to check Resident #1 and his room as the facility had no formal meeting about the gun incident. Staff F stated she believed it was communicated on the communication board on the unit but that was as far as it went. Staff F stated they had no meeting about security measures and everything she heard was from what staff learned from each other.</p> <p>During interview on 5/16/18 at 1:58 PM, Staff G CNA stated she worked the 6 AM-2 PM shift. She stated the day the gun was found, she walked in to the Administrator's office and saw the gun with a clip lock through it on</p>			

Page 15 of 44

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	<p>her desk. She heard Resident #1 had two clips and the gun was loaded. After finding the gun, staff were supposed to look in his bags, pockets and make sure he wore his wander guard. She had never been asked to check Resident #1 or his room nor did she ever do checks.</p> <p>During interview on 5/16/18 at 2:40 PM, Staff D stated she worked the 2 PM-10 PM shift. Staff D stated she was told Resident #1 could not leave the facility with visitors. Staff D believed staff should do random body checks on Resident #1 but no one asked her to do them.</p> <p>On 5/16/18 at 3:00 PM, when asked if he felt safe at the facility, Resident #1 replied of course; the staff here is awesome and so nice. Resident #1 stated he had no doubt his peers were safe too.</p> <p>On 5/17/18 at 8:13 AM the Administrator stated the reason for the care plan update on 2/21/18 was because of miscellaneous items found in Resident #1's room such as a small</p>			

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	<p>stick and something that looked like a knife. Unit staff found these items.</p> <p>On 5/17/18 at 8:28 AM the Operations Nurse Consultant stated not all employees have work emails, so she would have expected a meeting about the gun with all staff to have taken place.</p> <p>During interview on 5/17/18 at 8:56 AM, the ADON stated they updated Resident #1's care plan on 2/21/18 after finding a police baton in his room. She was unsure of the list of unsafe items given to Resident #1's POA and Resident #1. The ADON stated she is just learning about care plans and would get input from the Operations Nurse Consultant. She also stated Resident #1's ex-wife has a history of not keeping a close eye on him. When questioned why no search or check had been completed after the resident returned on 2/23/18, the ADON stated she did not know and could not be sure when they implemented the room check sheet; she thought it may have been 2/21/18 to track and monitor the searches. The ADON agreed the check sheet needed to be more detailed</p>			

Page 17 of 44

Facility Administrator

Date

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

<b>Citation Number:</b> <b>6812</b>		<b>Date:</b> <b>June 11, 2018</b>		
<b>Facility Name:</b> <b>QHC Winterset North</b>		<b>Survey Dates:</b> <b>May 14-17 &amp; May 21-24, 2018</b>		
<b>Facility Address/City/State/Zip</b>  <b>411 East Lane Street</b> <b>Winterset, Iowa 50273</b>		<b>MW</b>		
<b>Rule or Code Section</b>	<b>Nature of Violation</b>	<b>Class</b>	<b>Fine Amount</b>	<b>Correction date</b>
	<p>in the comments section as to what staff did and what is expected of staff.</p> <p>On 5/17/18 at 9:38 AM Staff Y LPN stated she worked on the unit while employed. Staff mentioned to do searches on Resident #1 but she was never asked to do them. Staff Y stated prior to the gun being found, Resident #1 could go off grounds with his ex-wife. After they found the gun, she believed Resident #1 could still go on visits with his ex-wife but his mother had to be there too.</p> <p>During interview on 5/17/18 at 12:18 PM Staff W CNA stated she heard about the gun being found in Resident #1's room but no one ever asked her to do a person or room check while working.</p> <p>On 5/21/18 at 11:05 AM Staff R CNA stated she works the 6 AM-2 PM shift on the unit, all the time. She stated that before finding the gun in Resident #1's room, they had found a police baton and knives and it seemed like every time he would go out with his ex-wife, is when he brought back those items. Staff R stated the Administrator stated Resident #1</p>			

Page 18 of 44

Facility Administrator

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	<p>could not go with his ex-wife and if he did, the nurses were to do searches. Staff R stated the searches were not being done and no one ever told to do them. She also stated that when management was not in the facility, the nurses were the ones to do them as they were in charge. Staff R stated she worked when he went out on 5/13/18 and he returned as she left for the day.</p> <p>During interview on 5/22/18 at 11:00 AM the Operations Nurse Consultant stated she could not find any behavior data for Resident #1 in his electronic health record. At 12:33 PM she also stated they could not find the list of unsafe items provided to Resident #1 and his POA.</p> <p>The police report filed on 2/27/18 at 11:37 AM recorded the Administrator reported Resident #1 had a loaded gun on the unit, police unloaded the gun and it was in their possession. The Administrator stated she would like to speak with an office an officer responded and Resident #1's family was contacted and a gun lock was placed on the</p>			

Page 19 of 44

Facility Administrator

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	<p>gun. The resident's family will make arrangements to pick up the weapon.</p> <p>Review of the facility's Firearm Policy revealed it is the policy of this facility to strictly prohibit firearms anywhere on facility property. This applies to residents, visitors and staff. On 5/16/18 the ADON made the following note: there are state laws that require postings at the doors and must be included in admission packet etc. This was looked into but not implemented due to the restraints.</p> <p>B. Review of Resident #1's care plan, revised on 4/30/18, revealed he had a recent elopement. The care plan documented the facility fixed windows to allow them only to open a small width with an initiated dated of 4/30/18. On 5/8/18, staff updated the care plan by placing Resident #1 on 15 minute checks.</p> <p>An Elopement progress note dated 4/30/2018 at 6:15 AM recorded Staff S entered the unit and began passing medication to other residents. At 6:35 AM, Staff S knocked on</p>			

Page 20 of 44

Facility Administrator

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<b>Rule or Code Section</b>	<b>Nature of Violation</b>		<b>Class</b>	<b>Fine Amount</b>
	<p>Resident #1's door and upon opening stated, knock, knock. I have your medication. She then turned on his light to see pillows arranged to look like a body under covers in his bed. Staff S called out resident's name again while looking in his closet and bathroom. When she could not find Resident #1, she exited his room and asked Staff R where he was. At this point Staff R started at one end of the hall and Staff S started at the other looking in every room, bathroom, closet, under beds and the dining room. When neither of them could find Resident #1, the Dietary Manager and Staff S looked out in the court yard. Staff S then paged overhead to all staff to assist Resident #1 to his room. Staff S exited the unit with Staff R and Staff A stayed on the unit. Staff S went to East nurse's station where all staff had gathered and informed two other CNAs to make a head count on all residents besides the unit as it had already been counted. At this time, Staff R paged Staff S to unit and stated she had found a note from resident stating he was leaving. Staff S called the Administrator and informed her of the situation as she was outside looking around the building. The</p>			<b>Correction date</b>

Page 21 of 44

Facility Administrator

Date

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	<p>Social Service designee and Dietary Manager proceeded to get into their personal vehicles and started looking for resident off facility property. The Administrator instructed Staff S to call the police and she informed 911 of the situation. An Officer entered building at 7:15 AM and took a statement. At 7:45 AM Staff S received notice that police found Resident #1 and he was back in the building. Staff S performed a head to toe assessment on the resident. Resident #1 had an abrasion to left shin measuring 1 centimeter (cm) x 0.5 cm, an abrasion to right thumb near palm measuring 0.5 cm x 0.5 cm, an abrasion to right wrist of 2 cm x 0.5 cm and abrasions/scratches to his abdomen around the naval. Staff placed the resident placed on 1:1 supervision at this time. Management called his family and Staff S called Resident #1's primary care provider.</p> <p>On 5/16/18 at 10:30 AM, during the observation and room search with Staff A, both windows had screws directly above the sliding window on each side, making four screws on his window panel. All four screws were tight. Each window had two release</p>			

Page 22 of 44

Facility Administrator

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	<p>latches with a white, dry substance covering the latches (informed this was gorilla glue).</p> <p>Observation on 5/15/18 at 4:00 PM revealed the following room windows without screws in them on the CCDI Unit:</p> <ul style="list-style-type: none"> <li>a. Room 303 one window with no screws;</li> <li>b. Room 305 one window with no screws;</li> <li>c. Room 302 both windows with no screws;</li> <li>d. Room 307 both windows with no screws.</li> </ul> <p>Observation on 5/16/18 at 10:39 AM revealed the CCDI unit doors leading to the 200 hall had a key pad to exit the unit. The doors remain locked until the code is entered. Staff S LPN stated the unit doors are not wander-guarded and believed the only door that is would be the front door. The unit doors leading to the 200 hall do not alarm when left open. The observation revealed silver magnets on the walls and doors to help hold the door open and the windows in the living room on the unit showed one out of four window panels had screws over the sliding window. The unit doors to the 300 hall also had a key pad to exit the unit and these doors remained locked unless the code is entered.</p>			

Page 23 of 44

Facility Administrator

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	<p>These doors also do not alarm if left open for an extended period of time. Silver magnets on the walls and doors of 300 hall also helped hold the door open. Resident #1's room is at the front of this hall, next to the unit doors. Continued observation at 11:00 AM revealed the unit doors joining the back half of the 300 hall lead to an exit door; this exit door is alarmed, once the door is opened and there is no key pad to enter a code prior to exit. Once outside, the exit it puts one in the same area where Resident #1 eloped from the facility on 4/30/18. Before getting to that exit door, the 400 hall leads to the dining room and the location of another exit door. This exit door is alarmed, once the door is opened and has no key pad to enter a code prior to exit. Once outside the exit door, it puts one in a grassy area with a broken fence leading to a residential area of town. All windows on the back half of the 300 hall and the 400 hall were not secured.</p> <p>On 5/17/18 at 8:56 AM a walk through on the unit was completed with the ADON to show her which windows still needed to be secured.</p>			

Page **24** of **44**

Facility Administrator

Date

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	<p>Review of the facility's 15 minute safety checks for Resident #1 revealed the following information:</p> <p>On 5/10/18 at 12:45 PM, he walked across the hallway into another resident's room and pulled back the curtains, checking the windows.</p> <p>On 5/15/18 at 12:00 PM, he looked at the windows in a neighboring room and staff told the resident he cannot go in to other's rooms.</p> <p>The ADON provided a list of residents in the facility that required a bed, chair and/or floor alarm on 5/22/18 which revealed two residents had alarms on the 400 hall, one resident had an alarm on the back half of the 300 hall and two residents had alarms on the CCDI unit.</p> <p>Review of the facility's Resident Care Policies and Procedure Manual related to Resident Elopements, revised on 4/5/02 revealed a missing resident audit tool will be completed and evaluated at the next quality assurance (QA) meeting. The resident's care plan will be</p>			

Page 25 of 44

Facility Administrator

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	<p>revised to reflect elopement and a prevention plan will be developed.</p> <p>During interview on 5/14/18 at 2:49 PM Staff R CNA stated she works the 6 AM-2 PM shift, on the unit all the time. When asked if Resident #1 had a history of attempting to leave the facility prior to the elopement, Staff R stated he had made comments when he first came in that he could find a lot of ways to get out of the facility. On 5/21/18 at 11:05 AM Staff R stated she has witnessed the unit doors being propped open on the 300 halls when she comes into work at 5:30 AM.</p> <p>On 5/15/18 at 8:50 AM Staff T Registered Nurse (RN) stated she worked the overnight shift and has witnessed the CCDI unit doors being propped open on that shift. When asked why they were propped open, she stated because they are short staffed. Staff T stated after Resident #1 eloped, the facility placed him on 1:1 supervision and he stated he planned to run again.</p> <p>During interview on 5/15/18 at 9:08 AM Staff A stated she works the 6 AM-2 PM shift and</p>		<b>Correction date</b>	

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	<p>has witnessed the CCDI unit doors propped open when she comes to work. Staff A stated she has heard Resident #1 say he still wants to leave the facility and has caught him going into to other resident's rooms, checking the windows. Staff A stated after the elopement, Resident #1 was on every 15 minute checks on the 6 AM-2 PM and 2 PM-10 PM shifts, and 1:1 supervision on the 10 PM-6 AM shift.</p> <p>During interview on 5/15/18 at 9:40 AM Staff M LPN stated she has witnessed the CCDI unit doors propped open down the 200 hall when she would come in for her 6 AM-2 PM shift.</p> <p>On 5/15/18 at 10:40 AM Staff Q overnight charge nurse, stated she had witnessed the CCDI unit doors propped open on overnights. When asked why they were propped open she stated because they were short staffed.</p> <p>During interview on 5/15/18 at 2:15 PM Staff I stated she has witnessed the CCDI unit doors propped open when she would come in for her shift. Staff I stated there would be a</p>			

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	<p>CNA at the entrance of the unit or at the end of the 300 hall and staff prop the doors open during break time.</p> <p>On 5/16/18 at 9:35 AM, Staff H stated when she would come in to work her 6 AM-2 PM shift she would see the CCDI unit doors propped open. The 300 hall unit doors that split the 300 hall are the doors she would see propped open when she would come in to work.</p> <p>During an interview on 5/16/18 at 12:20 PM, Resident #1's POA stated Resident #1 talked frequently about wanting to go to Alaska to start over.</p> <p>On 5/16/18 at 1:00 PM Staff S stated Resident #1 had made comments that he felt like a caged animal and has been witnessed going in and out of other resident's rooms looking at the windows. Staff S stated the screws that are in Resident #1's window frames are loose and they used gorilla glue on the releases in his room.</p>			

Page 28 of 44

Facility Administrator

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	<p>During an interview on 5/16/18 at 3:00 PM, Resident #1 stated he isn't allowed to go outside any more. Resident #1 stated he left the facility out his window, took the patio furniture to step on to his air conditioning unit and then climbed onto the roof. He stated once he was across the center of the building, he scaled down the roof and took off. Resident #1 stated he packed to heavy so he started to head back to the facility. He stated that is when the officer found him and he surrendered himself. When asked where he was going, he said he wanted to go to Alaska. Resident #1 didn't want to die and never have the chance to go to Alaska. Resident #1 stated he wants to exercise by walking outside. He stated he used to be a wrestler and needs to burn calories and get in to shape for his next excursion, but he stated 'you didn't hear me say that'. Resident #1 wanted to go outside and had no plans of escaping in broad daylight.</p> <p>On 5/16/18 at 3:50 PM, when asked for Resident #1's elopement risk assessment(s), the ADON stated the facility had an old elopement risk assessment tool they</p>			<b>Correction date</b>

Page 29 of 44

Facility Administrator

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	<p>previously used but do not use anymore. The ADON stated the admitting nurse had the discretion to put a resident at risk for elopement.</p> <p>During interview on 5/16/18 at 6:29 PM, Staff B stated she worked the 10 PM-6 AM shift and would prop the unit doors open on the 300 hall so she could go the bathroom. Staff B stated she would ask the CNA covering the back half of the 300 hall to watch the unit while she went to the bathroom.</p> <p>On 5/16/18 at 6:36 PM Staff X CNA stated when she has had to go to the bathroom, she had another aide from the 300 hall put a chair in front of the 300 hall unit doors. The doors were left open and the aid sat in front of the doors, looking down the hall.</p> <p>During interview on 5/17/18 at 12:18 PM Staff W CNA stated she worked the 10 PM-6 AM shift, always on the unit. She stated she has propped the unit doors open so she could go to the bathroom. When she props the doors open, she will ask the 400 hall CNA to watch the unit door while she goes to the bathroom.</p>			

Page 30 of 44

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	<p>Staff W stated there are no public bathrooms on the unit and she is only gone 2-3 minutes with the unit doors propped open.</p> <p>During interview on 5/21/18 at 11:05 AM Staff R stated she has witnessed the 300 unit hall doors propped open when she comes in to work her 6:00 AM-2:00 PM shift. When asked what would happen if a bed alarm would go off while the 300 hall aide watched the whole hall, she said good question.</p> <p>On 5/17/18 at 8:13 AM the Administrator stated the CCDI unit doors should never be propped open.</p> <p>On 5/17/18 at 8:56 AM the ADON stated staff have walkie-talkies to communicate with each other and should never prop the unit doors open. She also stated there is a communication board on the unit where staff post pertinent information, but other residents walk through this area and use the phone there so they stopped posting resident information. She stated the CNAs use a pad of paper to communicate information amongst each other. Staff R produced a pad</p>			

Page 31 of 44

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of paper with notes. When asked what she does with the pad once it is full, she stated they shred it and throw it away. The ADON stated the pad will now need to be given to management after it is full.  On 5/17/18 at 8:28 AM the Operations Nurse Consultant stated she will make sure all of the windows on the CCDI unit are secured. She also stated staff will be educated on not propping the unit doors open. She stated the electronic health record has an elopement risk assessment tool that should have been utilized.	<b>FACILITY RESPONSE:</b>			
<b>58.19(2)b</b>	<b>58.19(2) Medication and treatment.</b> b. Provision of the appropriate care and treatment of wounds, including pressure sores, to promote healing, prevent infection, and prevent new sores from developing; (I, II)  Based on clinical record review, facility policy review, professional reference review and staff interviews, the facility failed to provide	I	<b>\$6250 (Held in Suspension)</b>	<b>UPON RECEIPT</b>

Page 32 of 44

Facility Administrator

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	<p>the appropriate assessment and treatment of pressure ulcers to promote healing for one of 16 residents reviewed (Resident #6). The facility reported a census of 52 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated 2/3/18 documented diagnoses that included diabetes mellitus, unspecified pain, generalized edema, age-related osteoporosis and hypertension for Resident #6. The MDS documented she required the assistance of one with transfers and bed mobility, had total incontinence of bowel and bladder and no skin conditions at the time of the assessment.</p> <p>The care plan problem initiated 8/4/17 identified the resident with the potential for skin impairment due to incontinence and immobility. The care plan directed staff to consult the wound nurse and/or dietician as needed for skin breakdown as of 8/22/17 and to report any skin concerns to the nurse/doctor as of 11/20/17.</p>			

Page 33 of 44

Facility Administrator

Date

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	<p>The Braden Scale completed on 2/16/18 documented a score of 14 which indicated the resident at moderate risk for pressure sore development.</p> <p>A Physician Fax Order Request completed by Staff I, licensed practical nurse (LPN) on 4/7/18 documented the resident had skin breakdown to the lower left buttock which measured 4.0 centimeters (cm) x 5.0 cm with 2 small open areas which measured &lt;0.5 cm each. Staff I requested an order for Calmoseptine cream daily with resident care until healed. The physician approved the request on 4/9/18.</p> <p>Staff I completed a Non Pressure Skin Condition report on 4/7/18. During interview on 5/14/18 at 3:45 PM Staff I stated the skin condition on the lower left buttock was a pressure ulcer but she documented it on a Non-Pressure Skin Condition Report because it was the form available in the skin book. She stated she has not had much education on assessment of pressure ulcers. She requested an order for Calmoseptine Ointment for the area, but did not know if it</p>			

Page 34 of 44

Facility Administrator

Date

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	<p>should be applied to open skin. Staff I stated skin assessment updates are to be done on a weekly basis. There is no schedule for these; nurses are to check the skin book daily to see which ones need to be completed.</p> <p>Review of the Non-Pressure Skin Condition report for the left buttock revealed staff did not assess the area again until 4/19/18 at which time Staff S, LPN documented the area measured 2.2 inches (in) x 1.6 in (or equal to 5.5 cm x 4.0 cm) with no drainage or odor, epithelial tissue in the wound bed and normal surrounding skin and wound edges.</p> <p>During interview on 5/16/18 at 12:15 PM Staff S stated wound and skin assessments are to be updated weekly by the nurse. Charge nurses are to check the skin book daily to see which ones need to be completed but acknowledged she has often been too busy to check the book.</p> <p>A Wound Care*Skin Integrity*Evaluation reports completed by the consulting wound nurse on 4/20/18 documented the following assessment:</p>			

Page 35 of 44

Facility Administrator

Date

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	<p>Wound 1 - A full-thickness pressure ulcer over the left ischial tuberosity which measured 5.0 cm x 3.5 cm with a moderate amount of serosanguineous (reddish) drainage. The wound bed contained 25% red tissue and 75% black soft eschar (dead tissue). The wound could not be staged due to the presence of the eschar tissue. The wound nurse recommended a treatment application of calcium alginate with silver to the wound on the left ischial tuberosity and to cover with a semipermeable dressing. The physician approved the order as recommended on 4/20/18.</p> <p>The facility's undated Weekly Pressure Ulcer Progress Report Policy and Procedure directed the following:</p> <p>Policy: To provide weekly assessment and documentation of all pressure/stasis ulcers.</p> <p>To help prevent infections and other complications of pressure/stasis ulcers</p> <p>Responsibility: Licensed Nurse</p> <p>Procedure:</p> <ol style="list-style-type: none"> <li>1. Upon assessment of pressure/stasis ulcer, document on the weekly pressure ulcer</li> </ol>			

Page 36 of 44

Facility Administrator

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	<p>progress report.</p> <p>2. Documented complete assessment of site on the form including.</p> <p>    Stage</p> <p>    Size</p> <p>    Depth</p> <p>    Presence/absence of drainage</p> <p>    Odor/color</p> <p>    If culture obtained</p> <p>    Evaluate for and document any risk/casual factors</p> <p>    Documented physician, family, dietician notification</p> <p>3. Complete Incident/QA (quality assurance) report</p> <p>4. Document in Nurses Notes. The area will then be monitored on a weekly basis on the weekly pressure ulcer progress report</p> <p>5. Any signs/symptoms or poor response to treatment will be reported to the DON (Director of Nursing ) and to the physician for review for new orders</p> <p>6. Charge Nurse will assess the ulcer weekly and document</p> <p>7. Charge Nurse/Care plan nurse will be responsible to add skin issues to care plan with each incident to identify interventions to</p>			

Page 37 of 44

Facility Administrator

Date

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	<p>promote healing. The MDS coordinator will be responsible to follow up and monitor care plan and add updates as needed.</p> <p>8. Updated information regarding resident's skin condition and care plan will be reported to the certified nursing assistant (CNA's) for education to provide quality care and to heal and attempt to prevent further issues.</p> <p>Review of the resident's April, 2018 Treatment Administration Record (TAR) with Staff S revealed she applied Calmoseptine ointment to the left buttock pressure ulcer 8 of 11 days from initiation on 4/10 through the day of discontinuation on 4/20. Staff S stated the black tissue was present on all days she applied the ointment, she knew it should not have been applied to open skin, but just followed the order as written.</p> <p>According to Drugs.com, Calmoseptine is a menthol and zinc oxide ointment used for the following:</p> <ul style="list-style-type: none"> <li>A. protect skin from wetness, urine, or stools</li> <li>b. treat diaper rash</li> <li>c. treat minor cuts, scrapes or burns</li> <li>d. used at wounds or fistula sites</li> </ul>			

Page 38 of 44

Facility Administrator

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	<p>The site further directs not to put Calmoseptine on open or deep wounds, animal bites, infections, or very bad burns or cuts.</p> <p>During interview on 5/16/18 at 1:32 PM, Staff G, CNA (certified nursing assistant) stated she had been assigned to Resident #6's hall for the first time in a couple of months on 4/19/18. She noted the resident had a half-dollar sized scabbed over open area with surrounding redness on the left buttock crease as well as a spot on the right buttock crease the same size which was red but had no open skin. She refused to get the resident out of bed until the nurse could asses and/or treat the area. The Assistant DON and Staff S observed the wounds and tried to figure out what to put on them, Staff G stated the nurse eventually applied a clear film dressing to both areas.</p> <p>The Weekly Pressure Ulcer Record completed by Staff S on 4/19/18 documented a new skin condition on the resident's right buttock which measured 2.0 in x 1.3 in (equal</p>			

Page 39 of 44

Facility Administrator

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	<p>to 5.0 cm x 1.3 cm), with no odor and surrounding skin color pink/red. The record did not assess the wound bed or surrounding tissue/wound edges, the depth or amount/type of drainage or the stage of the pressure ulcer.</p> <p>The Physician Fax Order Request completed by Staff S on 4/19/18 documented the pressure sore on the resident's right buttock measured 1.3 in x 2.2 in, opposite of documentation on the Pressure Ulcer Record, and red/purple in color, not red/pink as recorded on the Pressure Ulcer Record. Staff S requested an order for treatment of the area. The physician ordered A&amp;D ointment to the area two times a day (BID) until healed. Review of the MAR and TAR for April, 2018 revealed no order for A&amp;D initiated as ordered.</p> <p>During the interview on 5/16/18 at 12:15 PM, Staff S stated she has been employed by the facility for approximately three months. She completed the wound assessment of the resident's right and left buttock conditions on 4/19/18; she was "pretty sure" the areas were</p>			<b>Correction date</b>

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	<p>pressure ulcers but she had not received education to know how assess and stage pressure ulcers. Staff S stated she has been told an RN (Registered Nurse) or a wound nurse should do it. She stated the physician ordered the A&amp;D ointment treatment, but the ADON told her it was not an appropriate order so she did not initiate it.</p> <p>A Wound Care*Skin Integrity*Evaluation reports completed by the consulting wound nurse dated 4/20/18 documented the following skin area:</p> <p>Wound 2 - A full-thickness pressure ulcer over the right ischial tuberosity which measured 2.0 cm x 2.0 cm with minimal serous drainage. The wound nurse recommended the A&amp;D ointment be discontinued and to apply a hydrocolloid dressing covered with a transparent film to be changed every 3 days and PRN. The physician approved the order as recommended on 4/20/18.</p> <p>Review of the Treatment Administration Record and Medication Administration Records for April, 2018 revealed the</p>			

Page 41 of 44

Facility Administrator

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	<p>physician orders for wound treatments ordered 4/20/18 had not been documented on either record.</p> <p>During interview on 5/14/18 at 3:45 PM Staff I reviewed her Progress Notes and TAR for Resident #6 for 4/21 and 4/22 and acknowledged there were no treatment orders to either area on the buttocks. Staff I then obtained a Cutimed Sorbion Sachet border dressing from the treatment cart and stated she thought this dressing it what she saw over both left and right buttock pressure ulcers.</p> <p>The Nurse Meeting held on 3/23/18 documented nurses were educated to the following system for processing physician orders:</p> <p>When a fax is received with a new order it is to be noted, a copy made and the original placed directly in the chart. The copy is to be attached to a triple check form, all processing steps to be completed, then placed in the "to be double-noted" basket. The 6A-2P and 2P-10P shifts are to process all orders when received. DO NOT LEAVE FOR THE NIGHT</p>			

Page 42 of 44

Facility Administrator

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	<p>SHIFT. Night shift is responsible for completing the second check of the order. When completed, the copy of the fax with attached triple check form is to be placed in the DON/ADON box outside their office and either will complete the third and final check.</p> <p>During interview on 5/16/18 at 4:20 PM the ADON stated the consulting wound nurse completed the treatment to both left and right ischial tuberosities as she recommended after her assessment of the areas on 4/20/18. She provided the triple check form with the original fax order for the wound treatments dated 4/20/18 on the box in her office and she acknowledged the triple check protocol had not been followed. Staff D, LPN verified her initial on the triple check form box which indicated she documented the order in the nurse's notes but Staff D did not transcribe the order to the MAR or TAR and did not order supplies from the pharmacy. Staff D verified the Night shift nurse Staff V, LPN temporary agency nurse also documented the order in the nurse's notes but did not do anything else. The ADON stated she has been very busy because the facility currently</p>			

Page 43 of 44

Facility Administrator

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	<p>has no DON and has not always had time to do all the third and final checks for physician orders.</p> <p>Resident #6's clinical record recorded she admitted to hospice care on 4/22/18 and expired in facility on the same date.</p> <p><b>FACILITY RESPONSE:</b></p>			