| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| ACCURA HEALTHCARE OF OGDEN, LLC | 625 EAST OAK STREET OGDEN, IA 50212 |

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| F 000 | INITIAL COMMENTS<br><br>Correction date: 12/21/18<br>The following deficiencies were identified during the investigation of incident #79902-I, and complaints #79954-C and #80375-C completed December 17-20, 2018.<br><br>Self Report 79902-I was substantiated.<br>Complaint 79954-C was substantiated.<br>Complaint 80375-C was substantiated. | F 000 | Accept this as the facility's credible allegation of compliance. | 12/21/18 |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview, the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 1 of 3 residents. Resident #7 had urine odor at several observations and did not receive timely incontinence care and had a urine contaminated mattress that was exchanged for new during the investigation. Facility census was forty-one (41) residents.<br><br>Findings include:<br><br>1. A Minimum Data Set (MDS) with assessment reference date of 9/6/18, assessed Resident #7 with a brief interview for mental status (BIMS) score of "9" (moderate cognitive impairment). The | F 677 | Resident #7 new assessment complete, MDS updated, and coded correctly. New mattress and cover placed on res bed.<br><br>All staff education provided via written in-service to ensure the facility's ability to provide services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>Director of Nursing or designee will perform random good grooming and personal hygiene audits to ensure compliance.<br><br>Any findings will be addressed in the quality assurance meeting. | 12/21/18 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| David Dietz LNHA | Executive Director | 01/04/2019 |

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 677 | Continued From page 1<br>resident required extensive staff assistance with bed mobility, transfers, and bathing and total staff assistance with toileting and personal hygiene. The MDS identified the resident as continent of bladder. A nursing progress note dated 7/1/18 revealed the resident used an indwelling catheter. On that date, the resident cut the catheter with scissors and, following that, staff removed the remainder of the catheter and the physician changed the indwelling catheter to PRN (as needed) straight catheter for urine retention.<br><br>On 12/20/19 at 12:25 p.m. the DON (director of nursing) stated the 9/6/18 MDS was miscoded. It was coded that the resident still used an indwelling catheter and was always continent and that was not correct. She stated they are in the process of completing a new assessment on the resident and they will code it correctly on the new MDS.<br><br>Observation on 12/17/18 at 9:23 a.m. showed the resident in bed with no shirt on. There was a very strong urine odor in the room. On the same date at 10:35 a.m. observation showed a hospice aide in the room to give the resident a shower. The resident's bed was wet with urine. The sheet contained visible urine rings. There was a very strong urine odor present. On the same date at 1:28 p.m. the resident was in his room in a wheelchair. The strong urine odor remained. At that time, the surveyor asked Staff H CNA when she last checked or changed the resident. She stated the resident was not checked or changed since he got his shower that morning. The resident lets staff know when he needs to go. The surveyor directed Staff H to let her know if the resident was checked or changed before she left that day at 2:00 p.m. Staff H did not get the | F 677 | | |

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| F 677 | Continued From page 2<br>surveyor. On the same date at 3:20 p.m. observation showed the resident in his room in a wheelchair with a very strong urine odor present.<br><br>Observation on 12/18/18 at 9:09 a.m. showed the resident in bed with a very strong urine odor present. The resident's gown was wet with urine and laying on the resident's overbed table. At 9:30 a.m. the surveyor spoke with Staff I CNA about cares for the resident. She stated he usually gets up around 10 a.m. and she would provide cares then At 9:39 a.m. Staff I CNA stated she was going to provide care to the resident early. Staff I CNA and Staff J CNA got the resident up from bed after incontinence cares. The resident's bed was soaked with urine and had of a very strong urine odor. There was a urine ring on the incontinent bed pad. When asked when the resident was last checked by staff, Staff I stated that was her first check of the resident. She stated she forgot the night shift said they did not change the resident all night because they said he was combative. At that time the surveyor examined the resident's mattress cover and mattress which was encased inside the cover. The cover had visible signs of dried urine and the inner mattress also had a urine odor. On the same date at 10:13 a.m. the surveyor spoke with the DON (director of nursing) about the urine odor and mattress concerns. The DON stated the resident is constantly wet. He has urine retention so when he does void, it has an odor. At 10:30 a.m. the DON stated she examined the mattress and cover and stated the resident needs a new mattress and cover. She will notify hospice. At 2:20 p.m. the surveyor asked Staff I if she checked or changed the resident since 9:39 a.m. that morning. Staff I stated, " no" the resident won't lay down for changing but she could ask | F 677 | | |

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| F 677 | Continued From page 3<br>him. At 2:36 p.m. Staff I reported the resident agreed to be checked and changed. At 3:40 p.m. Staff C and Staff K transferred the resident into bed via hoyer lift. The resident's brief was wet and he was smearing stool. At that time the DON stated the resident received a new mattress and cover.<br><br>Observation on 12/19/18 at 9 a.m. showed the resident in bed, with no urine odor in the room.<br><br>Care Plan:<br>Review of the resident's current care plan revealed an Intervention dated 8/8/18 that directed staff to check and change the resident upon arising, after meals, at bedtime and after any episode of incontinence and on request. | F 677 | | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents, which resulted in an immediate jeopardy to resident's health and safety. Resident #1 eloped without staff knowledge after multiple previous elopement attempts. The resident tried | F 689 | Past noncompliance: no plan of correction required. | |

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| F 689 | Continued From page 4<br>to elope via the 300 hall exit within 30 minutes of the actual elopement. There was no evidence of increased monitoring of the resident. The resident walked 750 feet on uneven ground in the dark, across a county road to a store where they called to alert the facility they had the resident. No staff heard alarms at the time of the elopement. A refrigerator was delivered on 11/20/18 through the 400 door that the resident eloped through on 11/23/18. Staff confirmed they disabled the local alarm on 11/20/18 but thought they turned it back on. There were no routine door alarm checks performed between 11/2/18 until 11/27/18. The facility did not follow the elopement policy by failing to identify high risk residents on the care plan. Facility census was forty-one (41) residents.<br><br>Findings include:<br><br>1. A Minimum Data Set (MDS) with assessment reference date of 11/21/18, assessed Resident #1 with impaired long and short term memory and severely impaired decision making ability. The resident had unclear speech and was rarely/never understood by others. The resident sometimes understood others. The resident had the following signs and symptoms of delirium that did not fluctuate: disorganized thinking and altered level of consciousness. The resident wandered daily. The resident required limited staff assistance with bed mobility, transfers, walking in room and corridor and eating. The resident used a walker for ambulation. The resident required extensive staff assistance with toileting and personal hygiene. The resident was frequently incontinent of bowel and bladder. A "balance during transitions and walking" test revealed the resident was not steady but able to stabilize without staff assistance in all areas of testing. The resident | F 689 | | |

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| F 689 | Continued From page 5<br>had diagnoses that included: Alzheimer's disease. The resident admitted to the facility 10/24/18.<br><br>An elopement risk assessment effective date 11/21/18 and completed 12/5/18 identified the resident a high risk for elopement. The risk assessment revealed the resident wore a wanderguard and was at increased risk for elopement.<br><br>A care plan dated 11/6/18 identified the resident with a history of wandering throughout the facility. At times the resident needed staff to assist him from another resident's room. An addendum to the care plan dated 11/23/18 identified the resident walked away from the facility unaccompanied. Prior to the 11/23/18 elopement the care plan directed staff to provide diversional activities and encourage activity involvement. Involve family to assist with interventions, labs and medications as ordered.<br><br>After the 11/23/18 elopement, the care plan directed staff to conduct 15 minute checks and door alarm checks every 2 hours.<br><br>An elopement investigation report prepared by Staff A RN (registered nurse) and dated 11/29/18 revealed the resident eloped on the PM shift. The resident was last seen pacing by the fireplace. The facility received a phone call from a store after the resident entered it. The resident was not injured. The temperature was 44 degrees and the resident wore a flannel shirt, jogging pants, shoes and socks. The question that asked when the facility realized the resident was missing was blank. | F 689 | | |

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| F 689 | Continued From page 6<br>Progress notes:<br><br>10/24/18 at 8:21 p.m. identified the resident admitted to the facility.<br><br>10/25/18 at 2:18 a.m. the resident wandered that night. Staff placed the resident in bed and he got back up. At 8:49 a.m. the resident continued to ambulate throughout the facility. The resident wore a Wanderguard. At 6:24 p.m. the resident continued to wander and require redirection from exits.<br><br>10/26/18 at 1:43 a.m. the resident continued to wander and try to go out doors. At 11 a.m. the resident attempted to go out the 300 hall exit.<br><br>10/27/18 at 12:39 a.m. the resident wandered and tried to go to doors to leave unit. The resident was easily redirected. At 9:42 p.m. the resident wandered the building exit seeking. Redirected easily since it was raining outside.<br><br>10/28/18 at 12:07 a.m. staff observed blood on the resident's right forearm measuring 1 millimeter (mm) by 1 mm in size likely from exit seeking and rubbing door frame of 200 hall door which resident attempted to leave through 3 times since 6 p.m. The stop sign was in place and alarms activated each time. Two of the times the resident had gone to bed and got up and tried to leave via the 200 hall door. 12:12 a.m. staff noted the resident to actively exit seek that evening and wander the hallways.<br><br>10/30/18 at 1:58 a.m. the resident wandered the unit going from one door to another trying to go off the unit. | F 689 | | |

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| F 689 | Continued From page 7<br>11/1/18 at 5:13 a.m. trying to go out doors<br><br>11/19/18 at 9:52 p.m. exit seeking throughout evening<br><br>11/20/18 at 3:01 a.m. up wandering<br><br>Elopement Progress Notes:<br><br>A late entry dated 11/23/18 at 7:41 p.m. and written by Staff A identified she saw the resident at 6:30 p.m. sitting by the fireplace. At 7:01 p.m. Staff A heard the 300 hall door alarm sound and saw the resident going out. Staff A called for Staff B CNA (certified nurse aide) to get the resident. Staff B got the resident and sat him down at the fireplace area. At 7:38 p.m. Staff A received a call from a store identifying the resident was at the store and someone needed to get him. Staff A then saw a red light on the alarm panel at the nurses station. (A red light indicates an exit door was opened and it was not reset) A nurse aide went to the store and got the resident. Staff A checked the resident over with his clothes on around 7:50 p.m. and did not observe injury.<br><br>An entry dated 11/24/18 at 2:59 a.m. and written by Staff A (regarding the 11/23/18 7:41 p.m. incident) revealed the resident left via the 400 hall door. The alarm was turned off and never alarmed. Staff picked up the resident and then checked the door hourly.<br><br>Staff Interviews:<br><br>Staff working when the elopement occurred:<br><br>On 12/7/18 at 1:53 p.m. Staff A stated staff was very busy at the time of the elopement. A resident | F 689 | | |

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| F 689 | Continued From page 8<br>was dying and she also had to sign for and check in medications. She never heard an alarm from the 400 door or the panel at the nurses station. She saw the panel had a red light on at the 400 hall exit but no alarm sounded. She stated someone told her they brought a refrigerator in the 400 door exit that day but couldn't recall who told her. Staff A stated they most likely turned the alarms off and didn't reset them after that so the 400 hall door alarms didn't work. She stated she got a call from a store and said someone was in there wearing a red flannel shirt. When the resident returned, he was fine. Staff A looked him over and he was ambulating and smiling. The rest of the night he was walking and walking. She stated no residents turn the alarm switches off. Staff A stated the resident needs a secure unit because he wants to get out. The resident has dementia and doesn't mean any harm. She stated the resident walks very well with and without a walker. She stated the resident opened the 300 hall exit and stuck his foot out before he left via the 400 hall. She stated she didn't do anything with the panel at the nurses station then. She just put the numbers in the local 300 exit door alarm to turn it off. She stated no one knew the resident was gone until the store called.<br><br>On 12/17/18 at 2:23 p.m. Staff B CNA stated after supper a store called and asked the nurse if the facility was missing a resident. They thought of Resident #1. Staff B last saw him around 6:30 p.m. The resident wanders after supper and opens doors and sets alarms off. Staff B stated there had to have been an alarm failure because no alarms sounded at the panel or door. He stated he did not mess with the panel unless its the front door sounding and he saw the person leaving. They didn't hear the panel for the 400 hall | F 689 | | |

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| F 689 | Continued From page 9 | F 689 | | |

exit. He stated he never saw a resident turning alarms off. On 12/18/18 at 2:05 p.m. Staff B stated after the store called, he noticed the stop sign at the 400 door exit hanging down and he went to the door. He stated he checked for snow on the ground because he was going to check for foot prints. There was no snow. Earlier the resident set the 300 door alarm exit off because he opened the door and set the alarm off. He didn't go out. Staff B didn't know if the alarm panel sounded at the time. He reset the 300 door exit alarm but not the panel. He didn't know about the refrigerator coming in.

On 12/17/18 at 3:30 p.m. Staff C CNA stated she heard the phone ring and someone asked if the facility missed a resident. Staff C drove over to the store. It was cold outside. The resident was smiling and calm. He was not shivering. She stated she did not hear any alarms. She doesn't know how to shut off the panel. She doesn'ttouch it. She had no idea about the local alarm at the 400 exit. She thought the resident was gone about 30 minutes and stated the resident needed to reside in a locked unit due to hiswandering. She never saw a resident at the panel before and never saw anyone at the panel that night.

On 12/18/18 at 2:01 p.m. Staff C CNA stated the resident's walker was visible 400 feet from the highway. It was in the upright position so the resident walked across the highway without the walker. He walked into the store and they spotted him and called the facility. Staff C stated it was dark and cold out. There was very little snow on the ground. The resident wore a white t-shirt, red flannel shirt, khaki pants and shoes. In her written statement. Staff C stated she saw the resident at 6:30 p.m. when she assisted residents from the

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| F 689 | Continued From page 10<br>dining room. Sometime after that Staff A informed her the resident left the facility and was at a store. Staff C got in her car at 7:35 p.m. and went to the store confirming the resident was Resident #1 at 7:41 p.m. She arrived back at the facility with the resident at 7:51 p.m. The resident was very happy and smiling.<br><br>On 12/17/18 at 12:07 p.m. Staff D CMA (certified medication aide) stated the resident was his usual self that night-opening doors and wandering. She stated she was positive she saw the resident at 7:30 p.m. and the store called at 7:38 p.m. After the store phone call, she saw Staff B at the 400 hall exit. Staff D thought Staff B about a year ago. Resident #5 flipped switches and pushed the reset button at the nurses station so they applied a silver bar over the switches. Since then, the resident has not messed with it. Since the incident the facility placed a plastic box over the panel. Resident #9 silenced the alarms in the past but he wasn't around that night. She stated she didn't hear any alarms until Staff B tested the door. Staff D stated the local alarm at the 400 door exit was turned off. At 2:55 p.m. Staff D showed the surveyor how the black tape over the switch was loosened and the switch was underneath. She again identified it as turned off when the incident occurred. She stated they did bring a refrigerator in through that door but she was not sure if it was the day of the incident.<br><br>On 12/17/18 at 2:10 p.m. Staff E CNA stated she came up the hall and someone told her a store called and they had the resident. They found his walker in the field behind the facility. She stated | F 689 | | |

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| F 689 | Continued From page 11 | F 689 | | |

she didn't know about alarms sounding. She didn't hear any alarm. She didn't flip and switches or silence any alarms. The resident seemed fine when he returned. She didn't know of a refrigerator delivered. She stated in the past a couple residents have silenced the panel at the nurses station. She stated Resident #9 had in the past and she reported it. She could not name any other residents.

Store employee interview:

On 12/18/18 at 2:30 p.m. the store employee stated she noticed the resident walk into the store with his nose running and no coat on. She stated it was "coat weather". The resident was quietly saying "pressure" "pressure" so they all thought he meant tire pressure. They got the resident a chair and he sat down. They then phoned the facility to see if they were missing a resident. The store employee stated the resident was there 15 to 20 minutes. She was concerned the resident would fall

Other staff:

On 12/17/18 at 3:09 p.m. the corporate delivery person stated he did deliver a refrigerator through the 400 exit on 11/20/18 after 2 p.m.

On 12/20/18 at 12:08 p.m., the surveyor asked the Administrator if she assisted with the refrigerator delivery and if she turned the 400 exit alarm off. At that time, the Administrator stated Staff D CMA turned it off during the refrigerator delivery. She stated the panel was not turned off. On 12/20/18 at 12:18 p.m. the surveyor asked Staff D if she turned the 400 exit door alarm back on after the delivery was complete. She stated

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCURA HEALTHCARE OF OGDEN, LLC | 625 EAST OAK STREET OGDEN, IA 50212 |

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| F 689 | Continued From page 12<br>she believed she did.<br><br>Maintenance:<br><br>On 12/13/18 at 12:35 p.m. the maintenance person stated he started employment about a week after the incident. He stated there was no maintenance person for most of November and according to what he had, the exit doors and alarms weren't being checked by anyone. At that time, he gave the surveyor a daily door check log. The last entry prior to the 11/23/18 elopement was 11/1/18. He stated he was not aware of any other logs or checks. At that time, Staff F housekeeping stated she was not aware of any other logs and also stated there was no maintenance person in November until the current person started (about a week after the incident). Staff F stated they just started new logs on 12/11/18.<br><br>Observation:<br><br>Observation showed on 12/13/18 at 12:55 p.m. the resident in bed. The surveyor asked the resident if he left the facility and the resident slightly shook his head. The resident then closed his eyes and didn't respond to any further conversation. At 1:15 p.m. the resident walked steadily with a walker, gait belt and one staff. The resident wore a Wanderguard to the left ankle. At that time, Staff G RN checked the bracelet for function with the Wanderguard checker. The checker revealed the bracelet was fully functional. At that time, Staff G stated the resident did not talk and could walk independently in the facility.<br><br>On 12/13/18 at 12:40 p.m. the surveyor checked all door alarms with the maintenance person. | F 689 | | |

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| F 689 | Continued From page 13<br>Each exit door other then the front door had a local alarm that activated when the door opened. All doors activated an alarm at the alarm panel at the nurses station. There was a small button that staff could push to silence the panel. All local exit door alarms except the 400 hall required staff to enter a code before it quit alarming. The 400 exit contained a small white alarm that activated when the door opened and when the door shut it quit sounding without any staff intervention to reset . It could also be turned off with a switch located underneath black tape. Since the incident a second local alarm was placed on the door. The new second alarm was a personal alarm that required staff intervention to reset. The front door contained a wanderguard and panel alarm. All doors activated and functioned properly. The only door that contained a Wanderguard was the front door.<br><br>Observation of the area outside the 400 hall exit revealed there was a light outside the exit door. On 12/18/18 at 11:30 a.m. the regional director stated the exit light illuminated the sidewalk outside the door. The sidewalk led to the north. The area to the west was uneven grassy area. If a person walked the entire grassy area it led directly to the county road speed limit 35 to 45 mph and then directly across the road the store where the resident went on the night of the elopement . The resident's walker was found in the grassy area. On 12/18/18 at 10:24 a.m. the maintenance person stepped off the distance from the 400 exit to the store. He stated it was 250 yards (750 feet).<br><br>On 12/17/18 at 3:25 p.m. Resident #9 denied silencing the alarm panel. The facility identified the resident with a BIMS of "15" (no cognitive | F 689 | | |

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| F 689 | Continued From page 14<br>impairment)<br><br>On 12/13/18 at 1:08 p.m. Resident # 5 stated he had silenced the alarm panel before and they just went through a training session. A 11/22/18 MDS identified the resident with a BIMS score of 12 (moderate cognitive impairment). Theresident thought the month was January and the year 2019. he thought he was inAmes. (All Incorrect)<br><br>Facility policy<br><br>An elopement risk/elopement process identified residents would be assessed for elopement risk on admission, readmission, quarterly, annually and with significant change MDS. If a resident is identified at risk the facility may apply an alarm bracelet (wanderguard), the care plan shall address behaviors using resident specific goals and/or approaches, a current picture of the resident would be maintained by the facility and facility staff would ensure that all exit alarms are responded to immediately. Staff will encourage activities that the resident enjoys to distract the resident.<br><br>The facility identified 14 residents as high risk for elopement. Three residents (including Resident #1) used wanderguard. Three of 14 residents had elopement potential identified on their care plans. Prior to exit on 12/20/18, the DON corrected the care plans.<br><br>Alarm logs<br><br>A daily door check log revealed the last check prior to the 11/23/18 incident was 11/1/18.<br><br>A logbook report identified a weekly door alarm | F 689 | | |

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| F 689 | Continued From page 15<br>check last completed prior to the 11/23/18 incident as 11/3/18. Checks resumed 11/24/18 by the current maintenance person. The facility identified the current maintenance person was hired on 11/26/18. On 12/20/18 at 12:22 p.m. the surveyor asked the Administrator how the current maintenance person could sign for alarm checks on 11/24/18 when he didn't begin employment until 11/26/18. She stated the current maintenance person actually completed the checks on 11/27/18 during training but it recorded as 11/24/18 because that was the date of the scheduled checks. The prior maintenance person left on 11/2/18.<br><br>On 12/18/18 at 10:20 a.m. the state climatologist identified the temperature at the time of the elopement as 43 degrees with a wind chill of 38 degrees.<br><br>The facility abated the immediate jeopardy on 11/23/18 prior to initiation of the investigation by implementing the following:<br><br>15 minute checks started 11/23/18<br><br>Door alarms assessed and additional pull tab alarm added to 400 hall door<br><br>One to one education done 11/23/18<br><br>All staff in-service scheduled for 11/29/18<br><br>Starting 11/23/18 and ongoing every 2 hour door alarm checks<br><br>Plastic cover over alarm panel at nurses station.<br><br>Wanderguard assessed. | F 689 | | |

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| F 689 | Continued From page 16<br><br>Administrator tested staff response to system | F 689 | | |