Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6909			**Date:** January 31, 2019
Facility Name: The Village		**Survey Dates:** January 9 to January 17, 2019	
Facility Address/City/State/Zip: 1203 North E Street Indianola, IA 50125	**MW/SS**		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
58.28(3)e	**481—58.28(135C) Safety.** The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) **58.28(3)** Resident safety. e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) **DESCRIPTION:** Based on clinical record review, observations, and staff and family member interviews, the facility failed to recognize a door alarm sounding, leading to the unknown exit (elopement) of one of four sampled residents (Resident #1). The facility reported a census of 52. Findings include: According to Resident #1's Minimum Data Set (MDS) assessment dated 11/14/18, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 2 indicating severely impaired cognitive skills for daily decision making. Resident #1 walked independently and required assistance with dressing, toilet use and personal hygiene needs. Resident #1's diagnoses included Non-Alzheimer's dementia, anxiety and restlessness and agitation. Resident #1 admitted to the facility on 10/31/17 and resided on a locked memory care unit.	**I**	**$ 7000.00 Held in Suspension**	**Upon Receipt**

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	Resident #1's care plan initiated on 10/26/18 indicated he will wander into other resident rooms and at times will try to leave the dementia unit. Approaches included moving Resident #1 closer to the nurse's station for safety, redirection and interaction strategies to help keep him calm. Interdisciplinary notes reviewed from 10/1/18 through 11/30/18 revealed several entries in which Resident # 1 wandered and/or attempted exit from the nursing facility. On 10/13/18 at 5:39 p.m. Resident #1 sought exit multiple times and set off facility door alarms. On 10/29/18 at 6:15 a.m. Resident #1 wandered and targeted exit doors. Resident #1 eventually opened an exit door into the stairwell and the exterior door outside. Staff redirected him back into the facility. On 11/18/18 at approximately 7:45 p.m. Resident #1 was escorted onto the memory care unit accompanied by three staff. Resident #1 wore pajamas and slippers and had no visible injuries. On 11/19/18, Resident # 1 woke at 4:00 a.m. and confused stating it was time to milk the cows. Resident #1 made several attempts to open the exit door and attempted to enter other resident rooms. In an interview on 1/14/19 at 3:00 p.m. Staff G, licensed practical nurse (LPN), stated prior to Christmas, Resident #1 was frequently wandering and pushing on doors. Staff G remembered him once exiting into the north stairwell. Staff G stated Resident #1 would not come back in and they left the alarm			

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	sounding until additional help arrived. Staff G stated standard protocol when door alarms sound is to respond immediately and verify the cause for the alarm. If there is not a clear reason for the alarm to sound, staff are to step outside and search and if still uncertain, conduct a head count of residents to ensure everyone is accounted for. In an interview on 1/10/19 at 2:31 p.m. a family member of another resident stated that on the evening of 11/18/18 she and her husband visited her father and walked back to the guest residence. As they exited the building through the blue doors into the meditation garden, they saw a male resident (Resident #1) walking towards them dressed in pajamas and slippers. Resident #1 stated he wanted to go home. The family member escorted Resident #1 back into the building and got someone to help. Review of the Device Activity Report on 11/18/18 indicated the south stairwell alarm activated at 7:35.04 p.m. and the front entrance into the memory care unit alerted at 7:39.44 p.m. The time frame from when Resident #1 first activated the south stairwell door alarm until visitors brought him back into the memory care unit measured 4 minutes and 40 seconds. A facility video (copy) of door (blue) in which resident was escorted back into facility did not contain a timestamp, but did record time. Based on video time and known Device Activity Report, Resident #1 exited the south stairwell at 7:35.19 p.m., was discovered by the visiting family at 7:36.30 p.m., escorted into the			

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	facility at 7:36.40, staff arrived at 7:37.14, other staff, including the Administrator arrived at 7:38.19 p.m. and escorted Resident #1 into the memory care unit at 7:39.44 p.m. Observation of the distance from the south exit to the blue door entry revealed approximately 115 feet of flat sidewalk with some elevated landscaping along the north edge of the sidewalk. The sidewalk was snow covered and the reported temperature measured 22 degrees Fahrenheit. The other direction lead to a small parking area, open grass field and residential neighborhood. In an interview on 1/15/19 at 12:10 p.m. the Administrator stated the evening of 11/18/18 he was in the facility when he learned that Resident #1 had been discovered outside by some visitors and escorted back in. The Administrator and two other staff responded to the hallway and escorted Resident #1 back to the memory care unit where he resides. Upon entering the memory care unit, the Administrator stated he could hear the south stairwell door alarm sounding. The Administrator stated the staff working on the memory care unit came from the dining room area (opposite side of the unit from south stairwell) and were unaware of the sounding door alarm or that Resident #1 exited. The Administrator had the south door alarm deactivated and tested it again. The south door alarm functioned properly and sounded. Staff A, LPN, stated she didn't hear the alarm and it didn't activate on her pager. Staff B, certified nurse aide			

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	(CNA) and Staff C, CNA also stated their pagers did not alert them of the door alarm. The Administrator stated they checked Staff B's pager and it had dead batteries. The Administrator replaced the batteries and then activated the door alarm again, this time noting that all three pagers alerted properly. The Administrator stated the staff were all re-educated on responding to door alarms and on the process of elopements. The facility is in the process of getting a Wanderguard system as a secondary system. The Administrator stated the door alarm volumes cannot be adjusted and they considered some form of an amplification system. The Administrator stated the Director of Nursing (DON) checked on the weather conditions for the evening of 11/18/18 and stated the temperature was 22 degrees Fahrenheit. In a follow up interview on 1/17/19 at 11:10 a.m. the Administrator stated when he had entered the memory care unit on 11/18/18 with Resident #1, he remembered requesting the pager from Staff A and remembered Staff A having to go back to the nurses station to get her pager. On 1/10/19 at 2:00 p.m. Staff A, LPN, stated she worked the evening of 11/18/18 on the memory care unit, in the dining room area supervising a tube fed resident and a couple of others who needed supervision. Her aides, Staff B and Staff C, provided resident cares in a room on the north side of the unit. Staff A stated it was only her second day working alone as a new nurse. She heard a faint buzzing sound but didn't recognize it as a door alarm and didn't respond to the area to investigate the sound. About			

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	that same time another resident walked into the dining room area from the south side of the unit. Staff A asked the resident why she was up (resident was in bed earlier). The resident stated because of that loud sound. At that time, Staff D, Staff E and the Administrator walked onto the memory care unit, escorting Resident #1. Staff A learned Resident #1 had exited through the south stairwell and was found outside. Staff A stated she carried the nurse pager and it never went off. In a follow up interview on 1/14/19 at 11:35 a.m. Staff A, stated she had been orientated regarding sounding door alarms and the standard response, but was not given demonstration on what a door alarm sounds like. Staff A stated they had pagers which were supposed to alert them if exit door alarms sound, but hers did not activate when Resident #1 exited through the south stairwell. Staff A stated the Administrator asked if the pagers alerted them and she told him no. The Administrator then tested the door alarm and pagers and Staff A stated her pager again did not activate when the south stairwell alarm was activated. In a follow up interview on 11/17/19 at 11:20 a.m. Staff A reiterated her pager did not sound on the evening of 11/18/18 when Resident #1 exited through the south stairwell. Staff A remembered her pager activated when the Administrator and others entered the memory care unit through the front entrance and she had the pager in her possession. Staff A stated as part of her shift responsibilities she has checked door exits for proper functioning, but noted she only checks to see if the green light is on and doesn't actually activate the			

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	alarm. In an interview on 1/14/19 at 8:36 a.m. Staff B, CNA stated she worked a double shift (day/evening) on 11/18/18. At around 7:30 p.m. she and Staff C were in a resident's room (1352 north side) assisting with a transfer and cares. The door was closed and they did not hear a door alarm sound. Once finished they walked into the TV/dining area as Resident #1 was being escorted onto the memory care unit. They were informed Resident #1 had eloped. Staff B stated she has a pager which will activate when door alarms sound, but her pager batteries were dead. In a follow up interview on 1/14/19 at 11:46 a.m. Staff B stated her pager was dead on the evening of 11/18/18. She worked a double shift that day and didn't make sure her pager remained charged. Staff B stated she usually places her pager on vibrate as the sounding alarm bothers residents, especially on the memory care unit. Staff B stated pagers are programmed specifically for each unit, but she did not know whether all pagers are set up to respond to all door alarms. In an interview on 1/10/19 at 3:37 p.m. Staff C, CNA stated she worked the evening shift on the memory care unit on 11/18/18 and around 7:30 p.m. she worked in room 1352 with another aide (Staff B) putting a resident to bed. The door was closed and Staff C could not hear any door alarms sounding. Staff C stated she left the room a few moments ahead of Staff B. When Staff C walked around the corner into the TV/dining room area, several staff were standing			

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	with Resident #1. Staff C learned Resident #1 had exited through the south stairwell and a visitor discovered him outside. Staff C stated she had a pager, but it never activated. Staff C stated she looked at the pager afterwards and it had no entry of the south door alarm sounding. In an interview on 1/10/19 at 10:50 p.m. Staff F, Housekeeping Supervisor, stated she is responsible for monitoring door alarm function each month and as needed issues are identified. Staff F stated a device activity report was printed out for the memory care unit on 11/18/18. Staff F stated when a door alarm activates, it will open after a 15 second delay and show up as cleared on the device activity report, but will continue to sound until manually deactivated by a key. In a follow up interview on 1/14/19 at 11:58 a.m. Staff F stated she checks door alarms each month to ensure door alarms are functioning properly, but does not document the checks. Staff F also runs off a report that will tell her what isn't working. Pagers are set up for each specific unit related to call lights and door alarms. Pagers that are not working will show up on the monthly report. Staff also have extra batteries at the nurse's station on each unit. Staff F stated she does not check alarm volumes at different locations on the unit. During an observation on 1/10/19 at 11:10 a.m. this surveyor, accompanied by Staff F, depressed the south stairwell door bar. The door alarm immediately sounded and opened following a 15 second delay.			

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	The alarm continued to sound until manually keyed off. The second door in the stairwell was pushed, but would not open. Staff F stated the door will not open unless keyed open; the facility locked the second door after the elopement incident. When tested, the three pagers on the memory care unit activated properly when the door alarm activated. This surveyor then walked to the far north side of the memory care unit and had Staff F activate the south stairwell door alarm. While in the north hallway, the tone was very faint and inaudible if in a resident room with the door shut. The TV/dining area was a little more audible, but still faint. On 1/14/19 at 12:27 p.m. the pagers were again tested on the memory care unit. All three pagers alerted within 20 seconds of the door alarm activating. In an interview on 1/16/19 at 2:30 p.m. the DON stated nursing staff are to check door alarms each shift and record the functioning status. Starting today, nurses have been directed to include checks of the pagers for proper functioning. The DON provided documentation of door alarm checks in each unit for October, November and December 2018.			

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	FACILITY RESPONSE:			

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