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	165272	A. BUILDING _____ B. WING _____	C 01/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK NURSING & REHABILITATION CENTER	233 UNIVERSITY AVENUE DES MOINES, IA 50314

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F 000	INITIAL COMMENTS Correction Date 1-29-2019 Investigation of facility-reported incident #80799-I and complaint # 80817-C resulted in facility deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	Plan of correction for University Park Nursing and Rehabilitation Center This serves as the credible allegation of compliance for University Park Nursing and Rehabilitation Center. We assert that all correctives described on this plan of correction have been implemented. In regards to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of actions. The staff of University Park Nursing and Rehabilitation Center is committed to delivering high quality healthcare to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that University Park Nursing and Rehabilitation Center is in substantial compliance as set forth below. We are confident that we will be found in substantial compliance upon re-survey. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. University Park Nursing and Rehabilitation Center has completed the following interventions as a result of the findings from survey exiting 1/28/2019.	
F 689 SS=J	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: Based on clinical record review, staff interviews, facility policy reviews and observation, the facility failed to provide adequate supervision for one of four sampled residents in order to prevent an unplanned exit (elopement) from the facility (Resident #1). The facility reported a census of 109 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated 12/14/18 documented a Brief Interview for Mental Status (BIMS) score of 11; a BIMS score of 11 indicated moderate cognitive and memory impairment. The MDS documented her diagnoses included heart failure, chronic lung	F 689	F 689 SS=J FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES: University Park Nursing and Rehabilitation will ensure that each residents environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident # 1 was placed on 1:1 observation during waking hours and 15 minute checks while sleeping until he/she was discharged from the facility on 1/16/2019. Residents were re-assessed for potential elopement risk by the MDS coordinator and licensed nurses. The facility elopement book was reviewed by the "IDT" interdisciplinary Team and updated accordingly.	1-29-19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jay Rogers | Administrator | 2-15-19

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.

POC accepted 2/19/19 VV

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F 689	Continued From page 1 disease,, Non-Alzheimer's dementia and depression. The MDS revealed the resident as independent with transfers and ambulation with the use of a walker. The assessment documented Resident #1 did not display behavioral symptoms or acute mental status changes during the assessment period. A Preadmission Screening and Resident review (PASRR) dated 9/5/18 identified additional diagnoses of recurrent major depressive disorder, with anxious distress/mixed features and to rule-out borderline personality disorder with depressive symptoms. The PASRR documented hospitalizations of 1/24/18 to 2/12/18, 2/26/18 to 3/22/18 and 8/1/18 to-9/7/18 with an admitting diagnosis of suicidal ideation. The PASRR indicated the resident needed services provided in a nursing facility. The PASRR also recommended that due to suicidal ideation and three psychiatric hospitalizations since January 2018, Resident #1 would benefit from the development of a crisis intervention/safety plan to reduce her risk of self-harm. Departmental notes dated 4/26/18 at 1:25 p.m. by the facility's social worker documented Resident #1 told another resident she was going to sneak out of the facility, walk to the river and jump and kill herself. Notes dated 7/6/18 at 11:07 a.m. documented the resident continued to have behavioral issues at times and had anxiety and impulsiveness which were manageable at the facility. Departmental notes dated 10/8/18 at 3:10 p.m. documented the resident's dementia was getting worse and her behaviors tended to worsen at night. Staff continued to do regular checks on her	F 689	The elopement book contains a copy of the elopement protocol policy, pictures of each resident determined to be at risk, and demographic information related to said resident. Staff were re-educated by the DON and facility administrator following the elopement on 1/12/19. Education included review of the elopement policy and procedure and immediate response to a missing resident. The elopement policy and procedure is reviewed with all new employees prior to working the floor as part of the new employee orientation process. All wander guard units are checked and documented on the TAR (Treatment Administration Record) each shift. Wander guard units are being used according to manufacture guidelines and observed on every shift for appropriate placement. Door alarms are checked weekly by maintenance. Documented elopement drills were increased to monthly covering each shift for the next three months and/or until compliance achieved. Residents at risk for elopement are reviewed in the daily QA (Quality Assurance) meeting and weekly risk management meetings to ensure care-plan interventions are appropriate to reduce the risk of elopement. Care plans have been reviewed by the DON and MDS coordinator on all residents deemed to be "at risk" for elopement based on the individual elopement assessment. Interventions were updated to ensure resident safety. Concerns identified will be addressed and reported in the facilities quality assurance compliance meetings for additional intervention as indicated. The facility was in substantial compliance on 1/25/19.	

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F 689	Continued From page 2 room for suicidal precautions due to a history of suicide attempts and battling depression. Departmental notes dated 10/17/18 at 2:55 p.m. documented Resident #1 refused her medications and told staff to leave her alone and let her die. The facility's social worker met with the resident and redirected her to take her medications. Departmental notes dated 1/12/19 at 10:55 p.m. documented at approximately 8:35 p.m. facility staff received a phone call from a hospital emergency room (ER) staff, who reported the resident had arrived in the ER at 8:20 p.m. Nursing staff tried to speak with hospital personnel but they had already hung up. Staff alerted the nurse on-call and reported a call had been received from the ER reporting the resident was at the ER. The nurse on-call directed staff to call the ER. Staff spoke to ER staff who reported the resident arrived in the ER approximately at 8:20 a.m. The resident's coat was wet and covered with snow. Facility staff asked ER staff to check the resident for a wander-guard bracelet on the resident. Hospital staff reported the wander-guard bracelet could not be found. Hospital staff reported the resident didn't tell them how she got there. The resident had reported her feet hurt and she felt suicidal after thinking about her daughter that died 14 years earlier. Departmental notes dated 1/12/19 at 10:58 p.m. documented staff revealed camera footage which showed the resident arrived on the main floor, pushing her four wheeled walker at 6:10 p.m. The resident removed her sweater and winter coat from underneath her walker seat, put both sweater and coat on and placed the walker	F 689		

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F 689	Continued From page 3	F 689		

away from the exit door. Resident #1 pushed the red button to disable the alarm and exited through the front door at 6:11 p.m. The resident's Wander-Guard (WG, a safety alert device) was on the walker per the care plan, but the resident left the walker at a distance far enough away the WG did not sound.

Departmental notes dated 1/13/19 at 1:31 p.m. documented facility staff received a call from hospital staff reporting the resident wouldn't be admitted and would be discharged back to the facility. The resident's power of attorney (POA) returned a call to the facility and voiced concern about the facility's ability to keep the resident safe and didn't feel 15 minute checks an appropriate safety measure.

Departmental notes dated 1/13/19 at 8:59 p.m. recorded a late entry that Resident #1 returned at 11:30 a.m. Notes documented the resident reported hospital discharge papers had not been sent. Staff completed an assessment which revealed no injuries. Staff placed a WG bracelet to the resident's right wrist and initiated 15 minute safety checks. A review of the 15 minutes check sheets revealed completion beginning 1/13/19 at 11:30 a.m. through 1/16/19 at 11:30 a.m.

Departmental notes dated 1/16/19 at 2:58 p.m. documented Staff A, a social worker, started looking for placement on locked units and today found placement in a locked unit. The writer noted attempts made in the past had been unsuccessful related to the resident being too high functioning. The facility had gone to court several times with attempts to get her court-committed for psych care and appropriate placement due to poor decision making although

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F 689	Continued From page 4 Resident #1 does well on the BIMS. The incident of last weekend (1/12/19), when she left the building, the resident's cognition allowed her to figure out how to leave without setting the alarm off. She knew to wear a coat and where she was walking to. Contributing to her exiting the facility included her POA telling the resident she would visit and then not coming to the facility. The resident responded negatively to these situations. In an interview the resident acknowledged she did not tell staff she would be leaving. Hospital ER records dated 1/12/19 at 8:23 p.m. documented hospital security found Resident #1 by the river. She planned to jump in the river to kill herself. Hospital ER records with a print date of 1/12/19 at 8:41 p.m. documented the resident reported being suicidal and planned to jump off a bridge. The resident stated she is sad because she did not want to live at the facility. The resident also thought of the death of her daughter 14 years ago. The resident stated she walked to the hospital from the facility. The resident's Care plan, with a problem onset revision date of 3/22/18, identified a crisis intervention/safety plan to reduce risk of harm to self or others related to threats of suicide, aggression toward others and non-compliance with her care plan. Interventions directed staff to report withdrawn behaviors and self-isolation, provide 1:1 interaction as needed to discuss her needs or provide emotional support if needed or to redirect behaviors. Initiate 15 minute checks as needed for suicidal thoughts, ideations or threats to harm self, shorten call light in bathroom, remove shower bar, lengthy call light removed from room, remove shoe laces and seek a court committal for psychiatric treatment if	F 689		

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F 689	Continued From page 5 resident exhibits signs of instability/suicidal/homicidal ideation. A physician's order dated 10/13/18 directed staff to discontinue the resident's 15 minute checks. The Care plan also identified a problem with the onset date of 7/2/18 that identified a risk for falls. Interventions directed the use an assistive device (walker) and to keep the walker within reach of the resident. A problem with the onset date of 9/2/18 identified self-care deficit potential related to mental difficulties, cognitive loss and major depression disorder. Interventions included placement of a WG due to a history of elopement attempts. The resident refused to wear the device on her person so staff placed the device on the walker. Interventions directed staff to check placement of the WG and complete safety checks at each shift. Clinical record review revealed a court order dated 11/6/18 at 9:42 a.m. ordering the resident for continued out-patient commitment. In this document the court, having received and reviewed a physician's report finding the resident to be seriously mentally impaired. The resident suffered from mental illness, lacked judgmental capacity by the fact she was likely to physically injure herself or others if allowed to remain at liberty without treatment. The resident was unable to satisfy her needs for nourishment, clothing, essential medical care, or shelter and likely would suffer physical injury, physical debilitation, or death. Medication Administrator Records (MARs) for 12/1/18 - 1/12/19 recorded the following medications administered to Resident #1:	F 689		

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F 689	Continued From page 6 Venlafaxine ER 150 milligrams (mg) - one tablet daily for major depressive disorder, Divalproex Sodium ER 1000 mg - 2 tablets at bedtime for major depressive disorder recurrent severe without psychotic features, Mirtazapine 30 mg - 1 tablet at bedtime, Trazadone 50 mg - 1 tablet at night for major depressive disorder, recurrent severe without psychiatric features. A review of MARs for this period revealed the listed medications were administered as prescribed. A facility document titled "Wandering, Unsafe Resident" with a revision date of 8/2014 revealed the policy statement stated the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for a resident who is at risk of elopement. Implementation interpretation directed staff to identify residents who are at risk for harm because of unsafe wandering, including elopement. Staff will assess at-risk individuals for potential correctable risk factors related to unsafe wandering. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions directed staff to maintain safety, such as a detailed monitoring plan. The facility completed Elopement/Wandering Risk Data Set assessments for Resident #1 on 2/16/18 3/28/18, 7/2/18, 9/14/18 and 12/14/18. Each risk assessment documented she had poor safety/environmental awareness, impulsive behaviors and the risk for elopement and placement of a WG pendent. A facility documented titled Elopement Policy (no date) defines elopement as: When a resident who is cognitively, physically, mentally, emotionally and or chemically impaired; wanders away, walks	F 689		

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F 689	Continued From page 7 away, runs away, escapes, or otherwise leaves a caregiving facility unsupervised, unnoticed, and or prior to their scheduled discharge. Should an elopement occur: 1. If a WG sounds or you come up upon a missing resident IMMEDIATELY check the entire area and this includes around the perimeter of the building. The WanderGuard (WG) Blue Tag information from the manufacturer documented the WG tag and controller issues an alarm and can lock a monitored door so an at-risk resident wearing the device cannot leave through the door. The resident typically wore the WG Blue Tag on the wrist like a bracelet. Additional information provided by the facility's WG representative on 1/25/19 at 10:04 a.m. instructed that a WG tag could be placed on a wheelchair but placement should be on a non-metal part of the wheelchair as touching metal could interfere with the WG signal. The email did not contain direction on tag placement on a resident's walker. Treatment administration records (TARs) for January, 2019 documented when staff verified placement and function of the wander-guard pendent. Staff were required to check placement and function of the device 4 times daily; 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. TARs for the period of 1/12/19 revealed staff had documented placement and function check of the wander-guard pendent at 8:00 a.m., 12:00 p.m. at 4:00 p.m. and no entry for 8:00 p.m. The Administration Record with a subtitle of (e-Tar), which documented the actual time of staff records in the TAR's showed the above entries (8:00 a.m. 12:00 p.m. and 4:00 p.m.) were made on 1/12/19 at 9:54 p.m. and not at the specified	F 689		

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F 689	Continued From page 8	F 689		

times identified on the TARs. These entries were made after Resident #1 left the facility and was in the hospital ER. Entries made 1/1/19 - 1/11/19 revealed at least 18 additional entries where staff did not check placement and function within the times documented on the TAR's.

A written statement dated 1/12/19 by Staff C, a certified nursing assistant (CNA) noted she started looking for Resident #1 at 7:40 p.m. She began by looking for the resident in her room but she was not there. Staff C went to the 3rd floor to look for her and asked another resident and friend of Resident #1 if she had seen the resident during the smoke break at 7:00 p.m. The resident reported she had not seen Resident #1. Staff C told Staff G, a licensed practical nurse (LPN) the resident wasn't in her room. Staff C then took the elevator to the 4th floor and upon arrival another CNA reported hospital staff had called and reported the resident was at the hospital.

In a written document dated 1/14/19, Staff A, the facility's social worker interviewed the resident. Resident #1 reported she felt down the weekend of 1/12/19 and admitted she hadn't told facility staff when she decided to leave or how depressed she was feeling. The resident stated when she got down downstairs (the evening of 1/12/19) she purposely parked her walker in a place where the WG alarm wouldn't sound. She pulled out her winter coat, walked to the front door, pushed the red button, de-activated the door alarm and walked out of the facility. She reported she then planned to walk to the river but decided not to and went to the hospital instead.

During an interview on 1/16/19 at 11:30 a.m.

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F 689	Continued From page 9	F 689		

Staff A, reported the resident had no recent history of exit seeking or elopement. The resident is high functioning and independent with most cares. She didn't show any signs of or stated thoughts of suicide. Her care plan had problem areas identified related to a history of depression along with interventions.

On 1/22/19 at 11:30 a.m. Staff B CNA reported she had seen the resident attempt to elope from the facility the summer of 2018; staff intervened before the resident left the facility. The evening of 1/12/19 shortly after 6:00 p.m. she noted the resident left her room. She had finished dinner in her room and walked by the nurse's station. The resident acted pleasant and talkative. The resident usually went downstairs to wait for the smoke break. She made no comments about wanting to leave (Note - the facility's smoking room is inside the facility and located on the 1st floor).

During an interview on 1/22/19 at 11:42 a.m. Staff C reported she worked at the facility for 14 years. On 1/12/19 she worked 2:00 p.m. -10:00 p.m. She reported she usually saw the resident in her room except for smoke breaks and Resident #1 would usually go a little early and wait until that time. (Facility records recorded smoke breaks are scheduled at 9:00 a.m., 1:00 p.m., 3:00 p.m. and 7:00 p.m.). Staff C reported the evening of 1/12/19 the resident appeared in good spirits and didn't tell anyone she wanted to leave. Staff C confirmed the original time (7:40 p.m.) she began to look for the resident.

On 1/22/19 at 11:56 a.m. Staff D, CNA reported the resident isolated herself in her room. The resident came out for smoke breaks and would

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F 689	Continued From page 10 go downstairs and wait for the break to begin. On 1/12/19 the resident sounded like she was in good spirits. The resident didn't express any feelings of sadness and no attempts had been made to leave the facility. On 1/22/19 at 12:54 p.m., the Director of Nursing (DON) reported the resident removed her WG wrist bracelet sometime in July 2018; she didn't recall why the resident had refused it. The resident agreed to have a WG bracelet placed on her walker. Wander-guard pendent placement and functionality checks were completed four times daily. The WG system, with one location at the facility's front door, is checked four times weekly along with entrance/exit door for all four floors and all exit doors leading outside. During an interview on 1/22/19 at 1:25 p.m. Staff F, Registered Nurse (RN) and 4th floor nurse manager reported Resident #1 would often stay in her room, in bed, for most of the day. She would come out early for smoke breaks and wait for smoke break to begin. She recalled the resident attempted to elope in January 2018 but was not certain of the date. During an interview on 1/23/19 at 1:00 p.m. Staff F reported the resident had been identified as an elopement risk because the resident didn't want to be at the facility. The resident's power of attorney (a friend) usually picked her up on Saturdays. The friend didn't come to the facility that day and the resident had been planning to see her that day. A document signed by and submitted by the Administrator (without a date) with a heading of "Smoke room review at 8:00 p.m. smoke break"	F 689		

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F 689	Continued From page 11	F 689		

documented Staff H and Staff I did not see Resident #1 in the smoke room on 1/12/19. A review of staff schedule for 1/12/19 listed both Staff H and Staff I working 2:00 p.m. - 10:00 p.m.

On 1/23/19 at 3:47 p.m. Staff H CNA reported she wasn't certain she worked the evening of 1/12/19. She stated staff didn't keep records of what residents attended smoke breaks.

During an interview on 1/23/19 at 3:54 p.m. Staff I CNA reported she worked the evening of 1/12/19 and did attend the smoke break at 7:00 p.m. She reported Resident #1 didn't smoke at the smoke break at 7:00 p.m. She recalled hearing the resident was at a local hospital that evening but no one had asked her to look for the resident earlier that evening.

During a second interview on 1/24/19 at 1:25 p.m. Staff A, reported she completed a number of elopement assessments (cited above titled Elopement/Wandering Risk Data). Each elopement assessment indicated Resident #1 as at risk for elopement because she had made verbal threats to leave the facility. Staff A reported she had documented some but not all of the threats she had made. She reported she had documented these threats in departmental notes. Staff A reported she believed the resident had been court committed to ICF level of care.

During an interview on 1/24/19 at 3:10 p.m. Staff F stated checking placement and function of the wander-guard pendent ensures the device is present and functional at the times specified on the TARs. This process also assures the resident's presence at the facility. Staff have one hour before and after the specified time noted in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165272	A. BUILDING _____ B. WING _____	C 01/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK NURSING & REHABILITATION CENTER	233 UNIVERSITY AVENUE DES MOINES, IA 50314

(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 689	Continued From page 12	F 689		

the TARs to visually check placement and function of the wander-guard pendent and resident safety.

During an interview on 1/24/19 at 3:25 p.m. the DON confirmed staff were to check placement and functional testing of the wander-guard at the assigned times identified in the TAR's.

Additional record review and observations revealed the following:

On 1/17/19 the facility provided a list of residents identified as at risk for elopement. This list identified 15 residents at risk of elopement. Of the 15 residents identified, Residents #1, # 3 and # 4 were identified as residents who wandered and had increased risk of elopement.

An observation on 1/22/19 at 3:10 p.m. revealed Resident #3 lying in bed and he appeared to be sleeping. The resident's wheelchair sat adjacent to his bed with a WG bracelet strap adhered on the back of the wheelchair on a top metal cross-bar which ran horizontal from side to side.

An observation on 1/25/18 at 11:10 a.m. revealed Resident #3's WG bracelet remained in the same position as on 1/22/19.

An observation on 1/28/19 at 12:15 p.m. revealed Resident #3's WG bracelet securely fastened to center of the top metal cross bar to a piece of foam placed over the cross bar.

An observation on 1/22/19 at 2:20 p.m. revealed Resident #4 sitting in her wheelchair. The resident's WG bracelet had been placed on the right side of a lower metal cross-bar, loosely

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F 689	Continued From page 13 dangling from the bracelet strap. An observation on 1/25/19 at 11:10 a.m. revealed Resident #4's WG bracelet had not changed position from the previous observation. An observation on 1/28/19 at 11:33 a.m. noted Resident #4's WG bracelet had not changed from where it had been placed earlier. However, a piece of clear tape had been placed on the inside of the bracelet strap. The incident detailed above resulted in an Immediate Jeopardy situation for residents of the facility. The facility abated the immediate jeopardy situation on 1/25/19 through a combination of efforts that included: a. Re-assessment of residents for elopement potential; b. Review of the elopement book (protocol and pictures of at risk residents); c. Staff re-education on elopement procedures; d. Direct observation of Resident #1, with subsequent transfer to a locked memory unit; e. Audit of the facility's WG system and door alarm checks; f. Continued elopement drills; g. Resident care plan review and updates, h. Placement of WG tags as instructed by the manufacturer.	F 689		