STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165537	A. BUILDING _____ B. WING _____	03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIAWATHA CARE CENTER	405 NORTH 15TH AVENUE HIAWATHA, IA 52233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Plan of correction: 4/15/19 The following deficiencies relate to the annual health survey and facility reported incident #81842. The facility reported incident was substantiated. See Code Federal Regulations (42CFR) Part 483. Subpart B-C.	F 000	This shall serve as a credible allegation of compliance. All deficiancies will be corrected by the completion date.	4/15/2019
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to identify and reassess a change in mental health according to the Preadmission	F 644	Hiawatha Care Center will continue to coordinate assessments using the PASARR screening process. Hiawatha Care Center will incorporate the r ecommendations from the PASARR level II. All level II residents will be referred to the appropriate entity as required. The QA&A committee shall assure compliance by periodicallyreviewing the PASARR process to assure compliance.	4/15/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/11/2019

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 644	Continued From page 1	F 644		

Screening and Resident Review (PASARR) for 1 of 1 sampled (Resident # 2). The facility reported a census of 105 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 8/18/19 revealed Resident #2 had diagnoses of dementia, psychotic disorder and behavioral disturbance. Resident #2 had severe cognitive impairments.

The MDS dated 8/18/19 revealed PASARR for Resident # 2 not considered by the state level II PASARR process to have serious mental illness and/or intellectual disability.

The PASARR dated 9/19/14 revealed Resident #2 had a negative level one screen. The PASARR documented Resident # 2 had no psychotic/delusional disorder and mild or situational depression. The PASARR directed in the event of an exacerbation related to mental illness, a status change should be submitted to the states-designated authority for further evaluation.

The Diagnosis Report dated 3/13/18 revealed Resident #2 had a diagnosis of psychotic disorder with delusions due to known physiological condition as of 10/18/17.

During an interview dated 03/11/19 at 03:49 p.m., Staff U (Care Plan Coordinator) stated Staff V (Social Services) handled the PASARR program.

During an interview on 03/12/19 1:34 p.m., Staff F (Assistant Director of Nursing) stated in a meeting the Social Services Staff reported

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F 644	Continued From page 2 Resident # 2 needed a new PASARR related to a changes.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656	Hiawatha Care Center will continue to develop/ implement comprehensive care plans. Compliance shall be maintained by the QA&A team periodically. Reviewing the comprehensive care plans to assume compliance is maintained.	4/15/2019

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F 656	Continued From page 3 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to create comprehensive care plans for 2 of 23 sampled (Residents #1 and #9). The facility reported a census of 105 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 1/24/19 revealed Resident #1 had a diagnosis of paraplegia. Resident #1 had severe cognitive impairments. The MDS documented Resident #1 required extensive staff assistance with activities of daily living and always incontinent of bowel and bladder. The Admission Nursing Assessment completed 10/18/18 identified Resident #1 unable to hold in stool and required occasional laxatives or enema. The Nurse's Notes entry dated 12/18/18 at 12:06 p.m., revealed Resident #1 had a distended and firm abdomen, no bowel movement for 8 days and received magnesium citrate this morning. The entry revealed the staff notified the physician. At 6:27 p.m., Resident #1 transported to the hospital by ambulance. The Care Plan failed to reflect Resident #1 had a problem with constipation. During an interview on 3/12/19 at 2:49 p.m., Staff	F 656		

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F 656	Continued From page 4 J (Registered Nurse) reported Resident #1 had a history of constipation and the staff administered milk of magnesia and Dulcolax. Staff J did not know who updated the care plans. Staff J reported is was not in her job description to work on the care plans. Staff J reported she would expect constipation to be identified as a problem on the care plan. During an interview on 3/13/19 at 9:54 a.m., Staff R (Licensed Practical Nurse) reported she completed the admission assessment in October of 2018. Staff R documented Resident #1 required laxatives. Staff R reported that should be addressed on the care plan. However, Staff R was unfamiliar with the process the facility used. During an interview on 3/12/19 at 2:24 p.m., Resident #1's family member reported Resident #1 was hospitalized for constipation when she lived at another facility. The family reported in the past Resident #1 had orders for Dulcolax suppositories every 3 days and a stool softener daily. 2. The Minimum Data Set MDS) assessment dated 2/23/19 revealed Resident #9 had a diagnosis of Parkinson's disease. Resident #9 had moderate cognitive impairments. The MDS documented Resident #2 required extensive assistance of one staff with bed mobility, transfers, dressing and toilet use. Resident #2 had an indwelling catheter. The physician's order dated 5/24/18 revealed Resident #9 had an indwelling catheter for urinary retention. The Care Plan failed to reflect Resident #9's had	F 656		

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F 656	Continued From page 5 a catheter. During an interview on 3/12/19 at 1:32 p.m., Staff F (Assistant Director of Nursing) stated catheters should be on the care plan. During an interview on 3/12/19 at 2:50 p.m., the Administrator stated the facility utilized the standard regulations as their facility policy on care planning.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657	Hiawatha Care Center will continue to provide care plans that meet the following; (i) Developed within 7 days after completion of the comprehensive assessment.(ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Compliance shall be maintained by the QA&A team periodically reviewing the care plans to assure all requirements are being met.	4/15/2019

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F 657	Continued From page 6 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview the facility failed to revise the plan of care plans for 2 of 24 sampled (Resident #1 and #184). The facility reported a census of 105 residents. Findings include: 1. The Minimum Data Set assessment dated 1/24/19 revealed Resident #1 had a diagnosis of paraplegia. Resident #1 had severe cognitive impairments. The MDS documented Resident #1 required extensive staff assistance with bed mobility, dressing and personal hygiene. The Admission Nursing Assessment completed 10/18/18 revealed Resident #1 unable to hold stool and required occasional laxatives or enema. The Nurse's Notes dated 12/18/18 at 12:06 p.m. revealed Resident #1 had no bowel movement for 8 days, had a distended and firm abdomen, received magnesium citrate this morning and the staff notified the physician. At 6:27 p.m., Resident #1 transported to the hospital. The discharge summary dated 12/24/18 revealed Resident #1 admitted to the hospital with abdominal pain and distension and vomiting. The radiology (x-ray) report showed a moderate to large colonic stool burden (stool stuck in the colon and difficult to pass). The Care Plan failed to identify Resident #1 had a constipation issue.	F 657		

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F 657	Continued From page 7 During an interview on 3/12/19 at 2:49 p.m., Staff J (Registered Nurse) reported Resident #1 had a history of constipation for which the nurses gave her milk of magnesia and Dulcolax. Staff J reported she did not update the care plans and did not know who updated the care plans. Staff J reported she would expect constipation to be identified as a problem on the care plan. During an interview on 3/12/19 at 2:24 p.m., Resident #1's family member reported Resident #1 had a hospitalization in December 2018 for constipation. Resident #1 lived at another facility and did not have a bowel movement for 8 days. The physician ordered a stool softener daily and Dulcolax suppositories every 3 days. During an interview on 3/13/19 at 9:54 a.m., Staff R (Licensed Practical Nurse) reported when she completed the admission assessment in October 2018 she documented Resident #1 required laxatives. Staff R reported the care plan should address the bowel issues. Staff R was not familiar with the care plan process. 2. The Minimum Data Set (MDS) assessment dated 3/4/19 revealed Resident Resident #184 had diagnoses of hallucinations and diabetes. Resident #184 had severe cognitive impairments. The MDS dated 3/4/19 revealed Resident #184 required limited assistance of 1 staff for bed mobility, dressing, toilet use and personal hygiene. The MDS revealed Resident #184 wandered and had a significant risk of getting to a potentially dangerous place. The Progress Note dated 3/1/19 at 4:17 p.m.	F 657		

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revealed Resident #184 attempted to exit two different doors.

The Progress Note dated 3/3/19 11:45 p.m. revealed Resident #184 attempted to push the door open and staff explained to him the door had an alarm on it and it was very cold outside.

The Progress Notes dated 3/4/19 3:00 a.m. revealed Resident #184 up and down tonight wandering in the hall and visiting with the staff.

Observation on 3/12/19 at 5:20 a.m., revealed Staff K outside the facility. Staff K pointed out tracks in the snow from Resident #184's wheelchair. Staff K reported this is where the staff found Resident #184 unattended.

The Progress Notes dated 3/4/19 5:20 a.m. revealed the staff found Resident #184 outside unattended wearing 1 slipper sock, a hospital gown (open in the back), and had brief around his ankles.

A 2/26/19 care plan entry stated the resident had hallucinations.

Care plan entries, dated 3/4/19, stated the resident had the potential for wandering and directed staff to answer door alarms per protocol and to walk outside and walk around corners, monitor and check the roam alert weekly and wanderguard daily.

A 3/7/19 care plan entry stated the resident wandered out the facility and directed staff to monitor the resident's whereabouts in the building.

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F 657	Continued From page 9 The care plan lacked documentation of interventions implemented to prevent elopement from 3/1/19 when the resident first displayed exit-seeking behaviors and 3/4/19 when the resident eloped from the facility. During an interview on 3/12/19 at 2:50 p.m., the Administrator stated the facility utilized the standard regulations as their facility policy on care planning.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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; This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews the facility failed to provide proper incontinence care for 3 of 7 sampled (Residents #11, #17, #48). The facility reported a census of 105 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 12/1/2018 revealed Resident #11 had diagnosis of dementia. The MDS revealed Resident #11 had severely impaired cognition. The MDS dated 12/1/18 revealed Resident #11 required extensive assistance with toilet use and totally dependent on staff for personal hygiene. The Care Plan directed the staff to assist Resident #11 with dressing and grooming.	F 677	Hiawatha Care Center will continue to provide ADL cares for all dependent residents. Proper incontinence care will continue to be provided to all dependent residents. Compliance shall be maintained by the QA&A committee conducting periodic reviews to assure proper ADL care is being provided.	4/15/2019

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F 677	Continued From page 10 During observation on 03/11/19 at 01:05 p.m., Staff D (Certified Nursing Assistant) assisted Resident #11 to the toilet. Staff D applied gloves and removed Resident #11's soiled brief. Staff D wiped Resident #11's buttocks with toilet paper from front to back and then applied a clean brief. Staff D failed to provide incontinence care. Staff D failed to change gloves before putting a clean brief on Resident #11. Resident #11 walked out of the bathroom. Resident #11's pants had a soiled area. Staff D assisted Resident #11 back to the toilet. Staff D applied gloves and removed Resident #11's soiled pants and placed clean pants on Resident #11. Staff D failed to perform incontinence care. Staff D confirmed Resident #11's brief was soiled when it was removed. During an interview on 03/11/19 at 01:37 p.m., Staff E (Nurse Aide) reported when performing incontinence care she wipes in a front to back motion and changes the washcloth or wipe with each swipe. Staff E reported incontinence care should be completed with each incontinent episode. During an interview on 03/12/19 10:56 a.m., Staff F (Assistant Director of Nursing) reported an expectation of staff to perform incontinence care when the resident is changed or toileted, regardless of whether the resident goes to the bathroom. Staff F reported all areas that touch brief touch are cleansed including the abdomen, inner thigh, pubis, buttocks and the hips. Staff F stated staff should change gloves when soiled, after removing a soiled brief and before applying creams or new brief.	F 677		

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F 677	Continued From page 11 2. The Minimum Data Set (MDS) assessment dated 12/8/18 revealed Resident #17 had a diagnosis of dementia. The MDS revealed Resident #17 had severe cognitive impairments. The MDS dated 12/8/18 revealed Resident #17 totally dependent on staff for all activities of daily living. The MDS revealed Resident #17 always incontinent of bowel and bladder. The Care Plan identified Resident #17 had a self-care deficit and directed the staff to check and change every few hours and as needed, monitor for signs and symptoms as is unable to relay this verbally and monitor daily for skin breakdown. Observation on 3/10/19 at 1:56 p.m., revealed Staff A (Nurse Aide) and Staff B (Nurse Aide) perform incontinence care. The Director of Nursing observed the cares. Resident #17 had bowel and bladder incontinence. Staff B failed to complete a glove change prior to applying barrier ointment and placing a clean brief on the Resident #17. Observation on 3/11/19 at 5:27 a.m., revealed Staff C (Nurse Aide) perform incontinence cares. Resident #17 had bowel and bladder incontinence. Staff C performed incontinence cares and failed to complete a glove change before placing a clean brief on Resident #17. During an interview on 3/12/19 10:55 a.m., Staff F (Assistant Director of Nurses) reported when providing incontinence care, she would expect the staff to change gloves before starting cares, after providing cares, after the resident had a	F 677		

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bowel movement and before applying any barrier ointment and a new incontinent brief.

During an interview on 3/12/19 at 2:05 p.m., Staff G (Nurse Aide) reported if the resident had bowel incontinence she would cleanse the resident, remove her gloves, sanitize her hands and put on new gloves on before applying any ointment or the new brief.

During an interview on 3/12/19 at 2:14 p.m., Staff H (Nurse Aide) reported if the resident had bowel incontinence she would cleanse the resident, remove her gloves, sanitize her hands and put on new gloves on before applying any ointment or the new brief.

During an interview on 3/12/19 at 2:24 p.m., Staff I (Nurse Aide) reported if the resident had bowel incontinence the staff should wear a gown and gloves, cleanse the resident, remove gloves, wash hands and put on new gloves before applying any new ointment or the new brief.

During an interview on 3/12/19 at 2:49 p.m., Staff J (Registered Nurse) reported after bowel incontinence the staff should cleanse the resident, remove gloves, wash their hands and apply new gloves before further cares.

In an interview on 3/13/19 at 9:54 a.m., Staff R reported after the resident had bowel incontinence the staff should change gloves, wash hands and apply new gloves.

During an interview on 3/13/19 at 8:50 a.m., Staff S (Assistant Director of Nurses) reported an expectation of staff to cleanse the resident after a bowel movement, remove contaminated gloves,

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	165537	A. BUILDING _____ B. WING _____	03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIAWATHA CARE CENTER	405 NORTH 15TH AVENUE HIAWATHA, IA 52233

(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 677	Continued From page 13	F 677		

wash their hands and apply new gloves before applying a new brief and ointment.
3. The Minimum Data Set (MDS) dated 1/12/19 revealed Resident #48 had a diagnosis of dementia. Resident #48 had severe cognitive impairments.

The MDS dated 1/12/19 revealed Resident #48 required assistance of one to two staff with bed mobility, transfers, toilet use, and personal hygiene. The MDS revealed Resident #48 always incontinent of bowel and bladder.

Continuous observation on 3/11/19 from 8:00 a.m. to 1:27 p.m., revealed resident #48 sitting in wheelchair in West Dining area. Resident #48 moved to lounge area after breakfast. Resident #48 attended an exercise activity and then sat front of the television. Resident #48's wife arrived and took Resident #48 to his room. Resident #48 rested in wheelchair. Resident #48 was assisted back to West Dining area for the noon meal. After the meal Resident #48's wife pushed him back to his room. Resident #48 waited for staff to provide cares. The staffed failed to provide repositioning and incontinent cares for 5 hours and 27 minutes.

Observation on 3/11/19 at 1:27 p.m., revealed Staff T (Nurse Aide) provided perineal cares for Resident #48. Staff T wiped the anterior perineal area from from back to front with a disposable wipe. Staff T wiped the posterior perineal from side to side.

The Care Plan dated 4/10/18 directed staff to assist resident with toilet use as needed.

During an interview 3/13/19 at 09:47 a.m., Staff T

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F 677	Continued From page 14 reported her normal routine for Resident #48 is to check on him around 6:00 a.m. during rounds. Then provide incontinence cares and assist out of bed. Staff T reported at 8:00 a.m. Resident #48 goes to breakfast. After breakfast, Staff T assists Resident #48 to an activity, leaves him at the nurses station or assists him to the television in the front lounge. Staff T reported if she gets the chance she will lay him down in the morning. If not, she will lay him down after lunch. Staff T reported she does not always time to get to him before lunch. During an interview 3/13/19 at 10:10 a.m., the Director of Nursing (DON) reported an expectation for the staff to provide routine toileting and check and change residents before and after meals and at bedtime and as needed. The DON reported the staff should assist the residents to the bathroom between breakfast and lunch. The DON reported an expectation of staff to wipe from front to back when performing perineal cares. The undated Incontinent Care policy revealed all residents will receive incontinence care every shift with morning and evening cares and as needed after each incontinent episode.	F 677		
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	F 689		

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F 689	Continued From page 15 accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the facility failed to provide adequate supervision to prevent elopement for 1 of 10 identified at risk for elopement which resulted in an immediate jeopardy to residents health and safety. Resident #184 has a history of wandering and exited the building without staff knowledge and was found outside in the snow. The facility reported a census of 105 residents. Findings: 1. The MDS (Minimum Data Set) assessment dated 3/4/19 revealed Resident #184 had diagnosis of dementia with behavioral disturbance and hallucinations. Resident #184 had severe cognitive impairments. The MDS dated 3/4/19 revealed Resident #184 required extensive assistance of 1 staff for transfers and walking. The MDS documented Resident #184 wandered for 1-3 days during the 7-day look back period. Resident #184 had significant risk of getting to a potentially dangerous place. The Care Plan dated 2/26/19 revealed Resident #184 had hallucinations and directed the staff to allow to share prior experiences on farm, share farm photos, medicate as ordered by physician and social service staff to offer one on one support if inappropriate with mood/behaviors. The Progress Notes dated 3/1/19 4:17 p.m. revealed Resident #184 attempted to go out two different doors.	F 689	Past compliance: no plan of correction required.	

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F 689	Continued From page 16 The Progress Notes dated A 3/3/19 11:45 p.m. revealed Resident #184 attempted to push the door open and staff explained to the resident the door had an alarm on it and it was very cold outside. The Progress Notes dated 3/4/19 3:00 a.m. revealed Resident #184 up and down "tonight", wandering in the hall and visiting with staff. The Progress Note dated 3/4/19 5:20 a.m. revealed at 5:00 a.m. Resident #184 not in his room and the staff searched the southwest hall. The staff exited the front door and found Resident #184 outside next to the second window on the right end of the building. Resident #184 had on 1 slipper sock and a hospital gown open in the back. Resident #184 had his incontinent brief around his ankles. The staff placed a jacket on Resident #148 and called for assistance. Resident #184 had 1 superficial scratch to the right elbow. According to the National Weather Service's (www.weather.gov) climatological data for Cedar Rapids, Iowa on 3/4/19, the low temperature was -9 degrees Fahrenheit with a high temperature of 7 degrees Fahrenheit. Facility documentation provided to the State Agency after the elopement stated the resident's body temperature was 96.3 degrees Fahrenheit on 3/4/19 at 5:25 a.m. During an interview on 3/12/19 at 5:01 a.m., Staff K (Licensed Practical Nurse) reported she heard the alarm sound, went to Door 3, observed the Velcro sign on the door undisturbed, looked out	F 689		

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F 689	Continued From page 17	F 689		

the window, did not see anything, silenced the alarm and went back to her work. Staff K reported 10 to 15 minutes later Staff P (Nurse Aide) asked if she knew Resident #184's location. Staff K reported they searched and found Resident #184 outside wearing a hospital gown and had a brief around his ankles. Resident #184 informed the staff he was fixing the air conditioner. Staff K stated called for assistance. The staff assisted Resident #184 indoors and completed an assessment. Staff K reported she did not receive education regarding door alarm protocol upon hire. Staff K stated she did not know she should not have silenced the alarm and should have completed a perimeter check. Staff K reported she received training after this elopement. The Assistant Director of Nursing told Staff K there was a plan to implement a training checklist so all staff receive the same training.

During an interview on 3/11/19 at 07:13 p.m., Staff P (Nurse Aide) reported Resident # 184 was at the Nurse's Station when she arrived to work at 10:00 p.m. Staff K Licensed Practical Nurse (LPN) assisted Resident # 184 to bed around 4 a.m. Later, during rounds, Staff P observed Resident # 184 out of bed and banging/tearing down the toilet paper holder. Staff P continued with rounds. Staff P then heard another resident calling out for help because Resident # 184 was in their room. Staff P assisted Resident # 184 back to his room and went back to rounds. Staff P heard the door alarm sounded and it went off right away. Staff P finished completing cares and went to check Resident # 184. Staff P checked Resident #184's room and then other resident's rooms and could not find Resident #184. Staff P noticed the Velcro strip in place across the door at the end of the Resident #184's hall. Staff P

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asked Staff K about the location of Resident # 184. Staff K acknowledged clearing the door alarm, looking outside, and not seeing anyone. Staff P reported she went to look for Resident #184 outside. Staff P reported Resident # 184 was found outside standing in the snow. Resident #184 had on one grip sock, a t-shirt and had brief around the ankles. Staff P reported Resident # 184 stated, "was working" and allowed the staff to assist him/her back in the building. Staff P reported 10 to 15 minutes lapsed from the time she heard the alarm sound and when Resident # 184 was brought back in the building. Staff P stated Resident # 184's skin was cold to touch and his body temperature was low per Staff K. Staff P reported Resident #184 did not have a wander device place to alert the staff when exiting. Staff P reported Resident #184 had a normal routine of getting up at that time of the day.

During an interview on 3/12/19 at 5:25 a.m., Staff L (Registered Nurse) reported she helped assist the Resident #184 indoors. Staff L stated it was "so, so cold" that night and the staff had to shovel Resident #184's wheelchair out of the snow.

During an interview on 3/12/19 at 5:38 a.m., Staff M (Nurse Aide) reported the staff shoveled Resident #184's wheelchair out of the snow. Staff L stated it was "cold" out and the cold and it got in her chest. Staff M reported Resident #184 wandered on other shifts and they had him sit by the nursing station.

During an interview on 3/12/19 at 6:20 a.m., Staff N (Nurse Aide) stated Resident #184 was a busy, back and forth in the hall, wandering into other resident rooms and looked out the window a lot.

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F 689	Continued From page 19 During an interview on 3/12/19 at 6:27 a.m., Staff O (Nurse Aide) stated Resident #184 had delusions and talked about the "farm across the lake". Staff O reported when an alarm sounded staff should go outside to look around. During an interview on 3/12/19 at 8:48 a.m., Staff F (Assistant Director of Nurses) stated after the elopement she went over the door alarm protocol with Staff K. She stated she did not know if there was paperwork on hire for Staff K. Staff K reported a plan to implement a checklist for new hires that included alarms. Staff F reported this elopement was the first time she knew of Resident #184 exit seeking. During an interview on 3/12/19 at 9:37 a.m., the Administrator stated he received a phone call that Resident #184 eloped. The Administrator stated if a resident was an elopement risk, they would have a wanderguard. The Administrator reported he spoke to Staff K. The Administrator reported Staff K should have left the alarm sounding and completed a head count. The Administrator stated he did not think the resident tried to get out the doors prior to the elopement. During an interview on 3/12/19 at 9:58 a.m., the DON (Director of Nursing) stated if an alarm sounded, she would not silence it until she knew the cause and stated she would have opened the door and looked out. She stated they did not have documentation Staff K signed upon hire regarding door alarms but stated moving forward they would go over the policy with all new hires. She stated the facility implemented a wanderguard for the resident after the elopement and stated she would place a wanderguard on a	F 689		

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resident who tried to get out the door. She stated she was not aware the resident had exit seeking behavior prior to the elopement.

Care plan entries, dated 3/4/19, stated the resident had the potential for wandering and directed staff to answer door alarms per protocol and to walk outside and walk around corners, monitor and check the roam alert weekly and wanderguard daily.

A 3/7/19 care plan entry stated the resident wandered out the facility and directed staff to monitor the resident's whereabouts in the building.

The undated Door Alarm Policy directed staff to identify which door alarmed and to go to that door and check for a resident outside. The policy stated this might require the staff member to go outside and check for a resident in the surrounding area.

The undated New Admission Risk Assessment Elopement Decision Tree policy stated if a resident had a history of wandering or opened doors to the outside, or made statements they were going to leave, staff would apply a wanderguard to the wrist or ankle.

The Door Alarm and Elopement In-Service Training Conducted sheets revealed the facility completed staff training on 3/8/19.

The facility abated the IJ on 3/8/19 by conducting in-service training regarding the door alarm and elopement policies. Because the facility abated the IJ prior to the start of the annual health survey and facility reported incident investigation, the

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F 689	Continued From page 21 situation was identified an IJ past non-compliance.	F 689		

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	IA0192	A. BUILDING: _____ B. WING _____	03/14/2019

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HIAWATHA CARE CENTER	405 NORTH 15TH AVENUE HIAWATHA, IA 52233

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L1093	58.12(1)l Admission, transfer, and discharge 58.12(135C) Admission, transfer, and discharge. 58.12(1) General admission policies. l. For all residents residing in a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility shall collect and report information regarding the resident's eligibility or potential eligibility for benefits through the Federal Department of Veterans Affairs as requested by the Iowa commission on Veterans Affairs. The facility shall collect and report the information on forms and by the procedures prescribed by the Iowa commissions on veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services. In the event that a resident is unable to assist the facility in obtaining the information, the facility shall seek the requested information from the resident's family members or responsible party. For all new admissions, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans affairs within 30 days of the resident's admission. For residents residing in the facility as of July 1, 2003, and prior to May 5, 2004, the facility shall collect and report the required information regarding the resident' s eligibility or potential eligibility to the Iowa commission on veterans affairs within 90 days after May 5, 2004. If a resident is eligible for benefits through the federal Department of Affairs or other third-party payor, the facility shall seek reimbursement from such benefits to the maximum extent available before seeking reimbursement from the medical	L1093	Hiawatha Care Center will continue to collect and report the required information regarding the residents eligibility or potential for eligibility to the Iowa Commision on Veterans affairs. Compliance shall be maintained by the QA&A committee periodically reviewing the residents files to assure compliance is maintained	4/15/2019

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	4/11/2019

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L1093	Continued From page 1 assistance program established under Iowa Code chapter 249A. The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II,III) This Statute is not met as evidenced by: Based on record review and staff interview the facility failed to check for Veteran's Benefits Eligibility for 2 out of 10 residents reviewed (Resident #68 and #78). The facility reported a census of 105 residents. Findings include: During the review of records for the residents checked for eligibility for Veteran's Benefits it was noted: a. Resident #68 admitted on 10/17/18 and had been a Veteran in the Army. He had not been reported to the Iowa Department of Veteran's Affairs (VA) as a resident residing in the facility and to check to see if qualified for any benefits from the VA until 3/12/19. b. Resident #78 admitted on 9/6/18 and had been a Veteran in the Navy. He had not been reported to the Iowa Department of Veteran's Affairs (VA) as a resident residing in the facility and to check to see if qualified for any benefits from the VA until 3/12/19. During an interview on 3/13/19 at 9:02 a.m., the Office Manager (OM) reported Social Services complete VA verification forms at admission and they give her the admission packet. She is responsible for entering information into the Electronic Health Record and submitting	L1093		

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L1093	Continued From page 2 information to the VA website. She is not sure why it was not done at time of admit for Resident #68 and Resident #78. Both were submitted 3/12/19 after surveyor asked for records. During an interview on 3/13/19 at 9:35 a.m., the Administrator stated the facility did not have a formal policy in regards to VA Eligibility verification, they follow the state rule.	L1093		