

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165251		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/08/2019	
NAME OF PROVIDER OR SUPPLIER RAVENWOOD SPECIALTY CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2651 ST FRANCIS DRIVE WATERLOO, IA 50702			
(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 Correction date: _____ Facility reported incident #83750-I and complaint #83941-C were substantiated. See code of Federal Regulations (45 CFR) Part 483, Subpart B-C.			F 000			
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 and observation, the facility failed to provide adequate supervision to prevent hazards from self and elements in the environment (elopement) for one of five sampled (Resident #1). Resident #1 had a history of wandering, exited the facility without staff knowledge, and traveled a half mile by foot into a residential and commercial area. The failure to provide supervision resulted in an immediate jeopardy to Resident #'s health and safety. The facility reported a census of 138 residents. Findings include:			F 689			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 689	Continued From page 1 1. According to the Minimum Data Set (MDS) assessment dated 4/22/2019 Resident #1 had moderately impaired cognitive skills for daily decision making, transferred and ambulated with oversight, required extensive assistance for dressing and personal hygiene. The MDS reported no wandering behaviors, no mobility devices, and diagnoses including hypertension, muscle weakness, anxiety, depression and benign neoplasm of brain. The Wandering Evaluation dated 1/22/18 and 4/22/18 revealed Resident #1 had a High Risk and included the resident had attempts to leave the facility since admission. The Care Plan dated 8/23/18 identified Resident #1 had an elopement risk related to disorientated to place, and staff witnessed an attempt to exit the A wing doors. The Care Plan directed the staff to alert others of wandering behaviors, distract from wandering, approach in a calm manner, apply a wander guard, transfer and ambulate independently with no assistive device, notice exits resident favors, place in an area where frequent observation is possible and place monitoring device on resident that sounds alarm when leaving the building. The Care Plan updated on 6/9/19 revealed Resident #1 exited the building and did not experience any injuries from the incident and directed the staff to provide 15 minute checks. The Care Plan updated 6/10/19 revealed staff education provided and door alarms modified after 6/9/19 incident.	F 689			

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F 689	Continued From page 2 The Physician Order Summary Report revealed an ordered dated 7/25/18 to check Wander Guard every shift for function. The Progress Note dated 5/12/2019 at 6:50 p.m. revealed the staff informed the nurse Resident #1 exited the back door on A wing. The staff escorted Resident #1 back indoors without any problems. At 7:30 p.m., the staff planned to continue 15 minute checks on Resident #1 and staff educated on answering alarms even if not on their assigned hall. Resident #1 rested in bed. The Progress Noted dated 6/10/19 at 9:55 a.m. revealed the staff planned to continue 15 minute checks and the secondary alarm modified. The Incident Report dated 6/9/19 at 6:30 p.m. by Staff A (Registered Nurse) revealed Resident #1 eloped from the facility. Staff A observed Staff B (Registered Nurse) assisting Resident #1 back indoors. Staff A last observed Resident #1 at 6:00 p.m. in the dining room. Staff B observed Resident #1 at 6:18 p.m. close to Ridgeway and 9th Street and assisted Resident #1 back to the facility by 6:20 p.m. Staff A completed a head to toe assessment and Resident #1 denied pain or discomfort, had intact range of motion to the upper and lower extremities and had no signs of trauma. Resident #1 had no signs of shortness of breath, bowel sounds present in all four quadrants, no visible injuries or skin breakdown and vital signs were within normal limits. The resident was alert, oriented to person, place and situation and ambulated without assistance. The facility investigation included the following: a. Resident #1 resided at the facility since July	F 689			

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F 689	Continued From page 3 25, 2018, ambulated without an assistive device and had diagnoses of brain neoplasm, anxiety, and hypertension and had moderately impaired cognition. Resident #1 had a wander guard device. b. On 6/9/2019, the door alarm on the skilled unit went off a couple of times. Each time the staff checked the alarm and found the paramedics set off the alarm. Staff C (Nurse Aide) cleared the alarm both times at the nurse's station after determining the cause. c. Around 6 o'clock p.m., the G wing alarm sounded and Staff C went to her hallway and a resident stated they saw a man just go out the door. Staff C immediately went to the end of the hallway and noticed the secondary alarm was undone. Staff C re-attached the alarm and informed the charge nurse of the resident going out the door. d. Staff immediately started a head count in the dining room, looking out the windows to see if they could see someone. The charge nurse then went to the hallway, opened the door and did not see anyone. e. As the charge nurse went to the nurse's station to clear the alarm, the front door wander guard system started going off. The nurse who clocked out at 6:09 p.m. brought Resident #1 back into the building. The nurse stated the resident was walking down the sidewalk. f. At 6:00 p.m., Resident #1 ate in the dining room and when finished ambulated out of the dining room to go back to his/her room. Instead of taking a right out of the dining room towards	F 689			

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F 689	Continued From page 4 his/her room, the resident turned left and ambulated down the incorrect hallway. The resident then removed the secondary alarm by reaching up high on the door and taking the string off the door hook and walked out of the building, looking to go home. g. Staff easily returned the resident to the facility. The facility estimated the resident remained outside less than ten minutes. h. Administration came to the facility to review the situation and determined staff did hear the alarm sounding in the hallway. Staff cleared the alarm at the nurse's station as the CNA went to check the hallway. At that time, the resident at one of the front rooms said someone just went outside, resulting in an investigation to see who went outside. The CNA appropriately notified the charge nurse who joined in the search to determine if indeed a resident went outside. i. Staff checked outside, started a head count on the skilled unit and by the time staff could alert the LTC (Long Term Care) side of the building, staff brought the resident back into the facility. The CNA received education to go outside immediately when a door alarm sounded to determine if someone is outside and to leave the alarm sounding until staff identified a cause. j. Conclusion: Resident #1 looked to go home after supper. The facility followed their protocol when a resident was potentially missing. A charge nurse who had just left, brought the resident back into the facility. The resident had the appropriate clothing and footwear. The resident re-enacted taking the secondary alarm string off the door hook. The facility modified all secondary alarms	F 689			

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F 689	Continued From page 5 so nobody can move the string that attaches to the door. The facility completes monthly drills and as needed to prepare for this type of occurrence. The resident is on 15 minute checks. Observation on 6/25/2019 at 9:00 a.m. revealed Resident #1 seated on the side of the bed eating breakfast independently. The resident had a wander guard bracelet on his/her right wrist. On 6/9/2019, Staff C (Nurse Aide) received a verbal warning for failure to fulfill job responsibilities. The G warning revealed the wing exit door does not have a camera on it. Any time an alarm goes off, you must verify the exact cause as to why it activated. After identifying the G wing door opened, go outside to visually check for a resident. Initial education given on Sunday, 6/9/2019 by the Assistant Administrator. On 6/12/2019, Staff D (Licensed Practical Nurse) received an employee coaching regarding the identified concern. The coaching revealed when a resident is potentially missing from the facility, call a Code Yellow immediately. The Employee Punch Report dated 6/9/2019 revealed Staff B (Registered Nurse) punched out of the facility at 6:09 p.m. The facility map revealed Exit G faced east towards St Francis Avenue with Covenant Hospital located across the street. The resident ambulated out G wing exit, used the sidewalk and turned right on 9th street towards Ridgeway Avenue. Resident #1 traveled approximately 0.5 miles before Staff B noticed Resident #1 and assisted him/her in returning to	F 689			

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F 689	Continued From page 6 the facility. The state climatologist reported on 6/9/19 at 6:00 p.m. a temperature of 66 degrees Fahrenheit in Waterloo. The facility Missing Resident policy included the following procedure when a resident is missing: 1. If after normal business hours, notify the Administrator. 2. Assemble all available Department Heads. 3. Organize and institute a thorough search of the facility and surrounding grounds and buildings. 4. If a search of the facility and grounds is not successful, notify the next of kin. 5. Notify the Law Enforcement. 6. Recall off-duty personnel as needed. 7. Notify local Civil Defense Agency and request search assistance. 8. Contact volunteer assistance. 9. Organize and institute an expanding search of the neighborhood surrounding the facility. 10. Notify known relatives, friends, and favorite stopping places that the resident is missing. 11. When resident is located, notify all agencies and individuals involved in the search that the resident has been found.	F 689			

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F 689	Continued From page 7 The facility Door Alarms policy given to all staff at orientation included: It is everyone's responsibility to respond to door alarms when you hear them sounding. If you are a non-nursing staff member, you can stay with the resident until a nursing staff member comes and assists the resident. Doors in the facility are equipped with two types of alarms. The first is a main door alarm that alerts when the alarm has not been disengaged (shut off), the second is a wander guard alarm intended to alert staff if a resident who is at risk for wandering exits the building. If a door or wander guard alarm is sounding, you need to go to the door where the sounding alarm is coming from and visually assess the area to figure out what caused the alarm to sound. This may include looking out a window or going outside in order to determine if any resident is outside unattended. You need to be able to explain or determine what caused the alarm to sound. If you are unable to, you need to let the charge nurse, supervisor or department manager know that the alarm was going off and you did not see anyone so that they can determine if a head count needs to be done. During an interview on 6/26/2019 at 10:17 a.m. the Administrator revealed Staff F (Assistant Administrator) responded to the incident related to Resident #1 exiting the facility, and came to the facility on Sunday, 6/9/2019. Resident #1 exited the G wing door after he/she unhooked the string attached to the TAB alarm. The door alarm sounded at the nurse's station while Staff B (Registered Nurse) gave report to the oncoming nurse. Staff C (Nurse Aide) thought all the exit doors had cameras and silenced the door after she thought Staff C checked the cameras. The facility had a busy evening with paramedics going	F 689			

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F 689	Continued From page 8 in and out of the facility. Staff B clocked out of the facility at 6:09 p.m. and observed the resident at 9th Street and Ridgeway Ave. Staff A (Registered Nurse) reported seeing the resident in the dining room at 5:45 - 6:00 p.m. Another resident reported to Staff C that someone went out the door. Staff C checked the door and saw the TAB alarm was not hooked, hooked it, looked out the window and failed to see anyone, checked on another resident who also had exit seeking behaviors and then went to inform Staff D (Licensed Practical Nurse). Staff D checked the G wing exit door and came up towards the front entrance when Staff B returned to the facility with Resident #1. Staff D had intended to call a Code Yellow at that time. Staff D received coaching related to the need to call a Code Yellow immediately. Staff C received a verbal warning for not determining the cause of the door alarm sounding prior to turning it off. Resident #1 made prior attempts to exit the facility though not successful until 6/9/2019. Staff F immediately began staff education regarding Code Yellow and alarm response and placed duct tape over the TAB alarm hooks. The facility maintenance staff crimped the TAB alarm hooks. The facility also practiced Missing Resident drills. Staff receive the Missing Resident policy in orientation and they review the policy along with drills routinely. During an interview on 6/26/2019 at 10:40 a.m., Staff B (Registered Nurse) reported she worked on 6/9/2019 until 6 o'clock p.m. on E wing. Staff B gave report and clocked out at 6:09 p.m. Staff B failed to recall hearing any door alarm between 5:45 and 5:55 p.m. Staff C assisted residents out of the dining room after supper. Staff B thought she saw Staff C near the F wing nurse's station computer at that time. If the G wing door opens,	F 689			

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F 689	Continued From page 9 an alarm sounds at the door and also at the nurse's station. A panel located at E and G wing nurse's station reveals which door opened. A monitor located at the nurse's station has a four way split screen that monitors E wing and Therapy exits. Staff B clocked out and 4 minutes later she spotted Resident #2 at 9th Street prior to reaching Ridgeway Ave. Resident #1 informed Staff B she was going home. Resident #1 recognized Staff B and agreed to get in Staff B's vehicle. Staff B called the front desk and told the receptionist that she had Resident #1 in her car. When Resident #1 walked through the front entrance the door alarm sounded and the staff immediately responded. During an interview on 6/26/2019 at 3:00 p.m., Staff D (Licensed Practical Nurse) reported working on 6/9/2019 when Staff C (Nurse Aide) informed Staff D that another resident observed a person walk out G wing door. Staff D assisted in the dining room at approximately 6:10 - 5:15 p.m. when Staff C notified him/her. Staff D began counting residents in the dining room, walked up to the G wing exit and checked it. Staff C had re-attached the string and the TAB alarm functioned. Staff D looked outside and failed to see anyone went to the nurse's station and silenced the alarm and as he/she walked towards the front entrance, Staff B and Resident #2 walked through the door. Resident #1's wander guard set off the front door alarm. Staff B reported finding Resident #1. Staff D never saw the resident in the area and never heard the alarm sound but Staff C may have been in that area. Staff cannot hear the G wing door alarm in the skilled dining room but can hear Therapy, E and F alarms. Staff remain in the halls during meal times. Resident #2 had no prior incidents of	F 689			

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F 689	Continued From page 10 exiting the facility. Nurses typically complete the 15 minute checks. During an interview on 6/26/2019 at 12:10 p.m. and 1:45 p.m. Staff A (Registered Nurse) reported she worked from 2:00 p.m. until 10:00 p.m. on 6/9/2019. Staff A assisted in the dining room from 5:30 - 6:30 p.m. Staff A never knew the resident had exited the facility until he/she returned with Staff B. Staff A did a head to toe assessment and found no injury. Staff A learned Resident #1 exited through the G wing exit door. The nurse completes the 15 minute checks. Staff A revealed he/she saw the resident around 6:00 p.m. sitting at a table. Staff A assisted another resident and never saw Resident #1 leave the dining room. Staff A had the 15 minute checklist in the dining room. Staff F (Assistant Administrator) arrived at the facility and made a copy of it the checklist. The 15 minute checklist completed by Staff A on 6/9/2019 revealed Staff A initialed the 6:00 p.m. slot, but failed to initial the 6:15 p.m. slot. During an interview on 6/26/2019 at 1:50 p.m., Staff C (Nurse Aide) reported working on 6/9/2019 on G wing. Around supper time, Staff C took residents to and from the dining room. Between 5:30 and 6:00 p.m., the door alarm went off and Staff C turned off the alarm thinking Staff B checked the monitor. Staff C also checked the monitor. Staff C assumed all exits had a camera since the monitor had four screens. Staff C reported she received training to check the door, go outside and check for residents, and report it. Staff C failed to ask Staff B if she checked the monitor. Approximately 10 minutes later a resident reported seeing someone walk out the door. Staff C checked the door and saw the TAB alarm string had been removed from the hook,	F 689			

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F 689	Continued From page 11 looked out the window and then went to check on another resident who had wandering behaviors, counted her residents and reported it to Staff D in the skilled dining room. Staff D came walking up the hall when Staff B came through the front entrance with the resident. Staff C reported the resident had wandering behaviors and sets off door alarms. Staff provide 15 minute checks. Staff C received a verbal warning for failing to check the door before silencing the alarm. During an interview on 6/26/2019 at 12:15 p.m., Staff G (Receptionist) reported working on 6/9/2019 from 10 a.m. until 6 p.m., Staff G observed Resident #1 leave the dining room and walk towards the front entrance door. Staff G informed Resident #1 she could not go out outside. Resident #1 repeated, "no outside", turned, and walked towards G wing. Resident #1 typically eats in the dining room at 5:30 p.m. and left with a coffee cup in her hand. Staff B called Staff G and said she had Resident #1, who had been down the street. The camera monitor at the receptionist's desk shows the front door and parking lot. The facility abated the immediate jeopardy on 6/9/19 by providing staff education on the door alarm policy and the elopement policy.	F 689			