STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166234	A. BUILDING _____ B. WING _____	C 03/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MANOR	516 THIRTEENTH STREET WELLMAN, IA 52356

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F 000	INITIAL COMMENTS Correction Date 3/31/21 A COVID-19 Focused Infection Control Survey was conducted by the Department of Inspection and Appeals on 1/6/2021 - 3/10/2021. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 41 Complaints #90298-C, #90826-C, #90835-C, #90989-C, #91015-C, #92403-C, #92718-C, #95202-I and #95387-C were investigated on 1/6/2021 - 3/10/ 2021. Complaint #90298-C was not substantitaed. Complaint #90826-C was not substantiated. Complaint #90835-C was not substantiated. Complaint #90989-C was substantiated. Complaint #91015-C was substantiated. Complaint #92403-C was not substantiated. Complaint #92718-C was substantiated. Incident #95202 - I was substantiated. Complaint #95387-C was substantiated See code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	F 000		3/31/21
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise	F 551		

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

Ryan Hammre Administrator

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 551	Continued From page 1 the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed	F 551		

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F 551	Continued From page 2 resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews, the facility failed to notify the resident's representative in a timely manner when changes occurred in the resident's physical condition requiring the residents to leave the facility or for routine medical/dental appointments for 2 of 3 residents reviewed, (Resident #6 and #7). The facility reported a census of 33 residents. Findings include: 1. The MDS (Minimum Data Set) assessment tool, dated 10/7/2020 listed diagnoses for Resident #6 included renal insufficiency, obstructive uropathy, and retention of urine. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as 13 out of 15, indicating intact cognition. A Progress Note dated 4/14/2020 at 4:07 a.m.,documented nurse attempted to change the catheter and contacted the ARNP (Advanced	F 551		

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F 551	Continued From page 3 Registered Nurse Practitioner), who directed her to have someone else try to change the catheter, and if unsuccessful, send to the emergency room for placement. A Progress Note dated 4/14/2020 at 7:16 a.m., showed Staff D attempted to change the catheter and was not successful. Sent to hospital Emergency Department as per order. In an email message on 4/15/2020 at 10:57 a.m., the DON stated she did not realize the nursing staff had not contacted the legal Guardian or Hospice of Resident #6 prior to 4/14/2020 transport to the emergency department. During an interview on 1/14/2021 at 8:22 a.m., the Guardian for Resident #6 stated she was not notified that the resident was transferred to the emergency department for catheter placement. During an interview on 1/14/2021 at 1:45 p.m., the DON stated she did not call Resident #6's Guardian when he went out for catheter placement. 2. The MDS, dated January 5, 2021 listed diagnoses for Resident #7 included hypertension, diabetes mellitus, and dementia. The MDS listed the resident's BIMS score as 3 out of 15, indicating severely impaired cognition. A Progress Note dated 2/19/2020 at 6:30 a.m., showed the resident was out for an appointment this a.m.. Medications given and breakfast provided prior to appointment. A Progress Note dated 2/19/2020 at 11:04 a.m., showed resident #7 returned from dental	F 551		

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F 551	Continued From page 4 appointment. A facility policy titled "Notification of a Change in a Resident's Condition," dated 11/1/2018 stated the attending physician/physician extender and the resident representative will be notified of a change in a resident's condition, per standards of practice and Federal and/or State regulations. During an interview on 1/14/2021 at 8:18 a.m., the Guardian for Resident #7 stated that she was not notified the facility made a dental appointment, nor did they notify her that the resident left to go to the appointment. During an interview on 1/14/2021 at 1:45 p.m., the DON (Director of Nursing) stated if residents are sent out to the hospital, the nursing staff calls the Resident Representative or family, so they can meet them at the hospital. Staff I makes the routine appointments for the residents and contacts the Resident Representatives/Family/POA (Power of Attorney), if the Resident Representative or POA does not make the appointment. During an interview on 1/21/2021 at 9:36 a.m., Staff D, RN (Registered Nurse) stated that she tries to document if she calls the POA or Resident Representative when they go out to the Emergency Room. During an interview on 1/25/2021 at 2:25 p.m., Staff I stated that she makes appointments, as needed, for the residents. Staff I stated she does not call the Resident Representatives. The nursing department calls the Resident Representatives, POAs, or the family.	F 551		

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F 573	Continued From page 5	F 573		
F 573 SS=D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner	F 573		

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F 573	Continued From page 6 the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g) (2) of this section may be made available to the patient at their request and expense in accordance with applicable law. This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview, state ombudsman interview, and record review the facility failed to provide a residents power of attorney for healthcare requested medical records in a timely manner for 1 resident, (Resident #14). The facility reported a census of 33 residents. Findings: During an interview on 2/3/21 at 12:44 p.m. Resident#14's power of attorney for healthcare (POAHC) had requested copies of her fathers medical records, on several occasions. The POAHC reported that she had verbally requested the medical records from the Administrator and Staff L, Social Services staff during the months of September, October, and November of 2020. The POAHC reported she had then asked for the assistance of the state ombudsman assigned to the facility. During an interview on 2/3/21 at 9:50 a.m. the State of Iowa ombudsman reported she had sent the administrator of the facility an email on 1/21/21 at 10:34 a.m., a list of the records requested by the POAHC of Resident#14. An email dated 1/21/21 at 10:34 a.m. addressed a request to the administrator of the facility to send copies of Resident#14's medical records to	F 573		

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F 573	Continued From page 7 the POAHC's home address. The email documented the POAHC's address, phone number and email address if the administrator needed anything. During an interview on 2/3/21 at 10:22 a.m. Staff L, and the Administrator reported that if records had been requested to be copied, the person requesting the records would have to be on the contact list. Staff L reported that during the admission process a form is filled out to see who can have access to the residents records. Administrator reported that if a record request had been made when the resident had been living, then a verbal consent is ok, unless it is a large number of records, then it would take some time. The Administrator reported that a POA (power of attorney), and POAHC is dissolved once the resident dies. The Administrator reported that once a person passes away the requesting of records is sent to the compliance officer at the corporate office. The Administrator reported that records requested are given within twenty-four hours, unless there is a lot to copy. .	F 573		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		

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F 686	Continued From page 8 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, family, and staff interviews, the facility failed to initiate and carry out treatments for pressure ulcers and failed to document assessments/measurements weekly on 3 of 3 residents reviewed with a skin shear or pressure ulcer (Resident #4, Resident #9, and Resident #12). The facility reported a census of 41 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed	F 686		

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F 686	Continued From page 9	F 686		

bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue) may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.

Unstageable Ulcer: inability to see the wound bed.

Other staging considerations include:

Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.

1. The MDS assessment tool, dated April 7, 2020 listed diagnoses for Resident #4 included type 2 diabetes mellitus, cirrhosis, and ulcerative colitis. The MDS showed the resident required extensive assistance of 1 for bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident required physical help in bathing with assist of one. The MDS showed the resident did not have any venous or arterial ulcers present. The resident was at risk for pressure ulcers and listed the resident's BIMS (Brief Interview for Mental Status) score as 13 out of 15, indicating intact cognition.

Hospital Discharge Records dated 3/31/2020 at

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F 686	Continued From page 10 10:02 a.m. revealed Resident #4 did not have pressure ulcers on discharge. A baseline Care Plan dated 3/31/2020 at 10:44 p.m. revealed Resident #4 admitted for skilled services to improve functional status with physical and occupational therapy services. The baseline Care Plan did not indicate Resident #4 had current skin integrity issues or a history of skin integrity issues. A Pressure Injury Risk report dated 3/31/2020 at 5:51 p.m. revealed Resident #4 at moderate risk for pressure injury. A Skin Observation Tool dated 3/31/2020 at 5:57 p.m. signed by Staff L, RN (Registered Nurse) noted skin irritation groin and inner thighs from moisture BUE (bilateral upper extremity) bruising and also on buttocks. A Nurse's Note dated 3/31/2020 at 12:46 p.m. signed by Staff L, RN noted Resident #4 had skin with multiple areas of bruising on buttocks and coccyx and BUE related to fall at home leading to hospital admission. Resident has some areas of scratching/open areas on scalp related to dryness. A Physician's Progress Note dated 3/31/2020 at 1:15 p.m. revealed Resident #4 present illness of enterocolitis due to clostridium difficile (inflammation of the colon caused by bacteria). The ARNP (Advanced Registered Nurse Practitioner) assessment of Resident #4 noted resident had chronic clostridium difficile and was occasionally incontinent of bowel and bladder per report. The Physician's Progress Note revealed the resident's skin with multiple areas of bruising	F 686		

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F 686	Continued From page 11	F 686		

on buttocks and coccyx and BUE related to fall at home leading to hospital admission. Resident had some areas of scratching/open areas on scalp related to dryness.

A Nurse's Note dated 4/1/2020 at 11:04 a.m. showed Resident #4 was continent of (able to control) bowel and bladder.

A Nurse's Note dated 4/4/2020 at 3:45 p.m. noted Resident #4 had been involuntary of stool.

A Skin Observation tool dated 4/7/2020 at 12:08 p.m. Staff L noted self-mutilation to BUE, cream applied per order and right heel with intact fluid filled area. 2.8 x 3.9 cm (centimeters). The residents record lacked any further Skin Observation tool completed prior to hospitalization 4/20/20.

A Nutrition History Report dated 4/7/2020 at 1:31 p.m. revealed no skin breakdown. The Nutrition History Report commented Resident #4 was on a 1200 milliliter fluid restriction.

A Physician's Progress Note dated 4/8/2020 at 11:30 a.m. revealed a diagnosis of urinary tract infection. The ARNP encouraged patient to increase fluid intake.

A Nurse's Note dated 4/8/2020 at 3:36 p.m. revealed Resident #4 with a fluid filled area to right heel. Resident educated on the importance of keeping heel protectors on when in bed, nutrition, and repositioning. ARNP aware.

A Nutritional Assessment dated 4/13/2020 at 3:29 p.m. by the Dietician revealed no skin breakdown and resident on regular diet with fluid restriction of

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F 686	Continued From page 12 2000 cc (cubic centimeters). An Infection Note dated 4/13/2020 at 7:15 p.m. revealed Resident #4 was incontinent of liquid stool. An Infection Note dated 4/14/2020 at 7:23 p.m. revealed Resident #4 was incontinent of liquid stool. A Nurse's Note dated 4/15/2020 at 2:26 p.m. revealed Resident #4 had four loose incontinent stools on that shift. A Physician's Progress Note dated 4/16/2020 at 11:30 a.m. revealed staff and patient requested to be assessed for concerns regarding diarrhea. New diagnoses of diarrhea and irritant contact dermatitis, unspecified cause were added to the EHR (electronic health record). ARNP encouraged patient to make efforts to decrease incontinence or get cleaned up quickly after incontinence. ARNP stated to apply Dermaseptin to buttocks after each loose stool and may keep Dermaseptin at toilet side. ARNP encouraged patient to increase fluid intake and education provided on dehydration. A Nurse's Note dated 4/16/2020 at 1:57 p.m. revealed Resident #4 had two loose stools on this day, fluid restriction, with 3+ BLE (bilateral lower extremity) edema (excess fluid in body tissue) and generalized BUE edema. A Nurse's Note dated 4/16/2020 at 5:55 p.m. revealed Resident #4 slid off the edge of the bed onto the floor. The note stated that his back was mildly red.	F 686		

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F 686	Continued From page 13 A Nurse's Note dated 4/19/2020 at 4:04 p.m. stated Resident #4 incontinent of stool. A Nurse's Note dated 4/20/2020 at 3:12 p.m. stated Resident #4 loose stool continue, increased weakness noted, and redness to groin. Resident alert with some confusion. DON (Director of Nursing) notified. ARNP to see resident in house tomorrow. A Nurse's Note dated 4/20/2020 at 5:15 p.m. stated the POA (Power of Attorney) called Staff D, RN with concerns the resident did not call her and when assisted to call her, he had difficulty carrying on a conversation. The Nurse's Note stated resident to be breathing heavily with increased confusion noted. Resident would start sentence and then not finish. Call placed to ARNP and new order to send to ED (emergency department) to evaluate and treat. DON notified. POA notified. A hospital emergency department triage note dated 4/20/2020 revealed the resident's entry to the ER (emergency room) at 6:09 p.m. The note stated the chief complaint was confusion, hypotension (low blood pressure), and cdiff (clostridium difficile). The note revealed the resident was unable to respond. A hospital emergency department triage note dated 4/20/2020 at 7:30 p.m. revealed the patient (Resident #4) was reassessed at 7:30 p.m. by the oncoming RN with redness of groin, buttock, inguinal area, and bilateral calves. Also, present with open sore on bottom, appears friction wounds, blenching buttock, sacrum Mepilex applied, and moon boots applied bilateral with Mepilex on right heel.	F 686		

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F 686	Continued From page 14 A hospital Admission Evaluation note dated 4/20/2020 at 10:38 p.m. revealed resident's initial skin assessment with the Braden Skin Risk Assessment score of 12, which indicated high risk. The same note included a skin assessment with wound #1 - pressure ulcer on right heel, size 3, red with 25% yellow and 75% black. Wound #2 - buttock left and buttock right with moisture dermatitis and Wound #3 - groin left and groin right with moisture dermatitis. Notes: Wound nurse consult initiated. Pressure ulcer protocol was implemented. A hospital Admission Evaluation note dated 4/21/2020 at 12:50 a.m., documented Resident #4 admitted to hospital from his nursing facility for altered mental status and hypotension. The note stated the resident's encephalopathy (damage or disease which affects the brain) was most consistent with infectious etiology at this time. UTI (urinary tract infection) is indicated by UA (urine analysis) positive for white blood cells and bacteria. Left lower extremity erythema (reddened skin), edema, and increased temperature concerning for cellulitis versus DVT (deep vein thrombosis - a blood clot deep inside body). Active issues include sepsis (life-threatening complication of an infection), uti, leukocytosis (high white blood cell count), cellulitis of left lower extremity (serious bacterial skin infection), urinary retention, and ulcer presence on admission. A policy titled "Skin Management Guideline," dated February, 2016 stated appropriate preventative measures will be implemented on all residents identified at risk and the interventions documented on the Care Plan. The policy also	F 686		

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stated the Care Plan is updated to reflect the new problem and interventions with evaluation and revision documented on an ongoing basis.

During an interview with the ARNP on 1/12/2021 at 11:41 a.m., the ARNP stated that she does a thorough assessment upon admission, documents thoroughly, and tries to be onsite daily. If bruising is observed during an assessment, there would be a stage or blanchable note, if it were a pressure injury.

During an interview with the Administrator on 1/13/2021 at 1:25 p.m. the ARNP entered and stated she remembered Resident #4 had incontinent episodes in which he sat in for long periods of time.

During an interview with the Director of Nursing on 1/14/2021 at 1:45 p.m., the DON stated the Care Plan for Resident #4 was not completed prior to discharge.

During an interview with the ARNP on 2/04/2021 at 3:34 p.m., the ARNP stated all pressure injuries should be unavoidable, unless there are extraordinary circumstances. The ARNP stated if a resident had an order for cream or medication to be kept at toilet side, it is usually because the family or the resident requested it to apply it themselves. Cognition of the patient is assessed before ordering a toilet or bedside medication.

During an interview with the DON on 3/4/2021 at 3:05 p.m., the DON stated that they try to do skin sheets weekly.

2. The MDS assessment tool, dated 1/16/2021 listed diagnoses for Resident #9 included type 2

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F 686	Continued From page 16 diabetes mellitus, non Alzheimer's dementia, and renal insufficiency. The MDS showed the resident required total assistance of 2 for transfers, extensive assistance of 2 for bed mobility, toilet use, and personal hygiene. The resident required physical help in bathing with assist of 2. The MDS showed the resident was at risk for pressure ulcers and listed the resident's BIMS score as 5 out of 15, indicating severely impaired cognition. A Care Plan entry dated 11/27/2020 revealed Resident #9 had a potential for/actual impaired skin integrity related to diabetes, immobility, incontinence, and diabetic foot ulcer. The Care Plan directed staff to encourage use of pressure reduction boot, offer toileting before and after meals and as needed, change clothing if soiled, check skin folds under breasts, pannus, groin, buttocks for red, irritated skin and report to nurse, apply chair cushion to wheelchair, keep dry, clean and use barrier cream, good pericare, and avoid friction/shearing while repositioning. A Pressure Injury Risk tool dated 12/30/2020 at 2:16 p.m. revealed Resident #9 as high risk for pressure injuries. A Skin Observation Tool dated 12/30/2020 at 2:18 p.m. revealed resident admitted from hospital with coccyx/sacral area red, blanchable and pink under pannus. In a Nurse's Note dated 1/5/2021 at 11:18 a.m., showed wife notified of skin issue and new order for Mepilex. In the January, 2021 Treatment Administration Record (TAR), an order was entered on 1/6/2021 for Meplix dressing to coccyx, change weekly and	F 686		

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F 686	Continued From page 17 prn (as needed), Stage II wound. A Nurse's Note dated 1/13/2021 at 5:53 p.m. documented the ARNP was notified regarding resident's bottom and use of Mepilex and barrier cream. Wound area very moist. Instructed to leave Mepilex off and will re-evaluate in the morning. During an observation on 1/14/2021 at 1:29 p.m., Staff M CNA (Certified Nursing Assistant) and Staff N CNA assisted Resident #9 with perineal care. The resident had an open wound on the coccyx area. Staff M gently cleansed the wound and the resident stated the wound was sore. The ARNP observed the wound and instructed the CNAs to offload and reposition the resident every two hours. A Skin Observation Tool dated 1/14/2021 at 5:05 p.m. revealed coccyx pressure 3 cm (centimeters) x 0.5 cm x 0.1cm - stage II. Pink wound base seen underneath scant, serous-fluid scab. In the January, 2021 TAR, an order was started on 1/15/2021 for calcium alginate to coccyx pressure ulcer. Cover with border gauze daily, one time a day for pressure ulcer. A Skin Observation Tool dated 1/18/2021 revealed resident coccyx pressure 3.6 cm x 1 cm and excoriation to bilateral buttocks. During an interview with the ARNP on 1/20/2021 at 2:26 p.m., the ARNP stated that pressure sores are avoidable most of the time. Poor nutrition and health decline can make some unavoidable.	F 686		

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F 686	Continued From page 18 A policy titled Skin Management Guideline dated February, 2016 stated appropriate preventative measures will be implemented on all residents identified at risk and the interventions documented on the Care Plan. The policy also stated the Care Plan is updated to reflect the new problem and interventions with evaluation and revision documented on an ongoing basis. 3. The MDS assessment tool, dated 11/13/2020 listed diagnoses for Resident #12 included heart failure, renal insufficiency, and atrial fibrillation. The resident required extensive assistance of 1 for bed mobility, transfers, toilet use, and personal hygiene. The resident required physical help in bathing with assist of one. The MDS showed the resident did not have any venous or arterial ulcers present. The resident was at risk for pressure ulcers and listed the resident's BIMS score as 14 out of 15, indicating intact cognition. A Care Plan entry dated 11/25/2020 revealed Resident #12 had a potential for/actual impaired skin integrity related to fragile skin and decreased mobility. A Skin Observation Tool dated 12/3/2020 revealed area on left buttock 5.4 cm x 7 and right buttock 4.5 cm x 1.7 cm with red, blanchable shearing on the right 0.3 cm x 0.2 cm. A Skin Observation Tool dated 12/7/2020 revealed open area to right buttock 2.3 cm x 1 cm, Dermaseptin applied. A Skin Observation Tool dated 12/14/2020 revealed open area to right gluteus shearing 4 cm x 0.7 cm.	F 686		

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A Wound Doctor Note dated 12/17/2020 revealed Resident #12 with a 0.5 x 0.5 x 0.1 cm shear wound to right buttock, light serous exudate. Treatment plan included house barrier cream apply once daily for 30 days.

A Skin Observation Tool dated 1/25/2021 revealed right buttock with stage II pressure ulcer measuring 1.8 cm x 1 cm x 0.1 cm, left buttock with stage II pressure ulcer measuring 2 cm x 0.8 cm x 0.1 cm, and coccyx with moisture breakdown. A note at bottom of page described the right buttock sore as well defined, approximately ½ while/yellow slough and smooth granular tissue. 9 x 5 cm. Pink/red surrounding with excoriation. Left buttock - same.

A Skin Observation Tool dated 2/2/2021 revealed left medial buttock with pressure/shear 0.8 x 0.5 x 0.1 cm. Left and right medial glutes with pressure/shear 9 x 4 cm. Notes included left buttock open area, active bleeding. Left and right glutes are pink, mild excoriation. Mild maceration to innermost aspect, approximately 6 x 1 cm.

The facility policy titled "Skin Management Guideline," dated February, 2016 stated appropriate preventative measures will be implemented on all residents identified at risk and the interventions documented on the Care Plan. The policy also stated the Care Plan is updated to reflect the new problem and interventions with evaluation and revision documented on an ongoing basis.

During an interview with Staff L on 1/20/2021 at 10:18 a.m., Staff L stated that 90% of pressure ulcers are avoidable. Staff L stated malnutrition, hydration, and whether they were turned every 2

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F 686	Continued From page 20 hours, plus the sliding can cause pressure injuries. During an interview on 1/26/2021 at 11:47 a.m., the DON stated that it was her expectation a resident should be repositioned every 2 hours or sooner, if the resident had pressure ulcers. During an interview on 1/27/2021 at 9:26 a.m., Resident #12 stated he developed a pressure sore from sitting so much and his bottom is sore. Resident stated that he is not repositioned regularly due to not having options to reposition in his recliner. During an interview with the ARNP on 2/4/2021 at 3:34 p.m., the ARNP stated all pressure injuries should be unavoidable, unless there are extraordinary circumstances. She stated that due to lack of time, she left wound treatment and orders to the wound doctor during the COVID-19 outbreak. During an interview with the DON on 3/4/2021 at 3:05 p.m., the DON stated that they try to do skin sheets weekly.	F 686		
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	F 689		

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F 689	Continued From page 21 by: Based on observation, staff interview, and facility policy the facility failed to provide adequate supervision for one of five residents that the facility staff identified as cognitively impaired but independently mobile. (Resident#13), which resulted in immediate jeopardy to resident health and safety. The resident that eloped from the facility had combative and wandering behaviors. The facility failed to execute the missing person's policy in a timely manner, and failed to ensure door alarms had been in working order. The resident had eloped from the facility, and had not been found for 2 hours and 45 minutes. The resident census had been 33 at the time of the incident. Findings Include: The Quarterly Minimum Data Set (MDS) Resident Assessment dated 11/2/20 documented Resident#13 had severely impaired cognitive skills for daily decision-making. The MDS documented the resident had wandering behaviors four to six days per week. The resident had been independent with walking in his room, but required limited assistance when out of his room, and the resident did not require an assisted walking device. The resident had required assistance of one staff member for toilet use, and personal hygiene. The resident had diagnoses including non-traumatic brain dysfunction, anxiety, depression, insomnia, and alzheimer's disease. The Resident's Care Plan with focus area initiated date of 9/28/20 documented as follows; the resident is at risk of elopement as evidence by; cognitive impairment, expresses desire to leave	F 689		

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F 689	Continued From page 22 the facility, history of wandering, impaired safety awareness, new admission, and unfamiliar with surroundings. The Care Plan documented an intervention on 1/18/21 as follows; elopement intervention - alarm on west door to be checked twice a day, new alarm installed and placed where nurses could hear. The Care Plan documented a revision date of 12/11/20 with the following interventions; Distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Identify the resident's pattern of elopement: is exit seeking purposeful, aimless, or escapist? Is the resident looking for someone or something? If the resident exits the building, do not leave unattended, walk with the resident and/or keep within eyesight. Monitor the residents location closely. Document elopement behavior and attempted diversional interventions in the progress notes, and behavior log. Motion sensor alarm on doorway of the resident's room to alert staff if he leaves his room at night. Provide structured activities for the resident such as, toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. The Care Plan documented the intervention without a date as follows; Notify supervisor, director of nursing, and administrator immediately of any successful exits from the building, and follow the facility elopement protocol. The Resident's Care Plan documented a focus area on 9/24/20 as follows; the resident had potential to be physically aggressive related to dementia, and history of harm to others, and poor impulse control. The Resident's Care Plan documented a focus area on 10/8/20 as follows; the resident had been prescribed psychotropic medication, due to continued outbursts and physical aggression.	F 689		

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F 689	Continued From page 23 The Elopement-Wandering Risk Scale dated 9/2/20 and 11/9/20 documented a score of 14. The score according to the tool documented a resident with the score of 11 or above had a high risk to wander. The indicators included the resident had been ambulatory, could not communicate, had a history of wandering, and had medical diagnosis of dementia/cognitive impairment; diagnosis impacting gait/mobility or strength. During an interview on 1/25/21 at 1:45 p.m., the Director of Nursing reported the resident had changed the sound on the alarm. During an observation on 1/25/21 at 1:01 p.m., the resident stood very close to the nurse at the medication cart while the nurse had been setting up medications. During an observation on 1/25/21 at 1:45 p.m., the motion alarm sounded in Resident#13's bedroom, three people responded promptly, the resident stood at the entrance of his bedroom without signs of distress. During an observation on 1/26/21 at 9:00 a.m., the resident stood in the main dining area, and wandered around the tables getting close to other residents. During an observation on 1/27/21 at 1:33 p.m., the resident stood in the main dining room supervised by staff, the resident had non-skid socks on. During an observation on 1/27/21 at 4:00 p.m., a staff member provided the resident with one on	F 689		

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F 689	Continued From page 24 one by walking alongside the resident down the hallway. During an observation on 1/28/21 at 11:00 a.m., the resident rested on the couch by the front door supervised by staff. During an observation on 1/28/21 at 2:00 p.m., the resident had been by the front door a staff redirected the resident. . The Nurses Note dated 9/3/20 at 4:18 a.m. documented the resident wandered in and out of the isolation hall up to the nurse's station, and had been redirected back to his room by staff multiple times to no avail. The resident had gone into another resident's rooms, and had been redirected. The night shift spent one on one time with him to help with his anxiety and restlessness. The resident had slept since about 2:35 a.m.. The Nurses Note dated 9/3/20 at 10:44 a.m. documented the resident wandered frequently and required redirection. The Nurses Note dated 9/5/20 at 10:33 p.m. documented the resident had opened and walked over to the west door, a Certified Nurses Aide secured the resident, and returned him to his room. The charge nurse had been advised of the incident. The Nurses Note dated 9/24/20 at 9:02 p.m. documented the resident had been wandering in the facility without incident until approximately 8:30 p.m. Staff had attempted to redirect the resident from handling a pitcher of water in the nurses station, in response the resident hit the Certified Nurses Aide in the stomach, and then	F 689		

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F 689	Continued From page 25 again in the back. The nurse redirected the resident out of the nurses station at that time. The resident then went down the west hall and stopped at the activity office door, and proceeded to break the lock and enter. The staff attempts of redirection only escalated the resident's aggressive behavior. The nurse walked with the resident towards his room to assist him to bed, halfway down the south hall the resident turned around to go back to the common area/nurses station. When the nurse asked the resident if he had been tired, the resident drew back his fist. In response, the nurse asked if the resident would hit her, and the resident stated, "I wouldn't put it past me!" The resident behavior continued to be unpredictable. The resident appeared to have targeted another male resident, and had followed him all over the common area in an aggressive or threatening manner. The said male resident had been directed to his room for safety at that time. A Certified Nurses Aide distracted the resident and the nurse gave Resident#13 Lorazepma (anti-anxiety medication) 0.5 milligrams intramuscularly injection at 9:20 p.m. without incident. The Nurses Note dated 9/26/20 at 4:40 p.m. documented the resident begun wandering at dinnertime in the dining room, refused to sit down, and stood closer than six feet to other residents. The resident had been given Lorazepam as ordered. Approximately 30 minutes later the south door alarm had sounded, a nurse exited the front door of the building and visualized that Resident#1 had pushed open the south door and had exited the building, the nurse assisted the resident back into the building without incident.	F 689		

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F 689	Continued From page 26 The Nurses Note dated 9/26/20 at 5:31 p.m. documented the resident continued to wander through the lobby. The resident had noted to become agitated when attempting to redirect the resident to maintain social distance from other residents. The resident stood right next to another resident and tensed up and balled up his fist when attempts had been made to redirect the resident. Lorazepam intramuscularly administered per orders. The Nurses Note dated 10/3/20 at 9:32 a.m. documented staff reported at 7:35 a.m. the resident had been in the dining room and punched another resident in the face, breaking said resident's eyeglasses. The facility Nurse Practioner ordered Resident#13 to be sent to the emergency room for evaluation and treatment. The Nurses Note dated 10/13/20 at 9:14 a.m. a Certified Nurses Aide reported that the resident wandered into two different residents rooms during the shift. The Nurses Note dated 10/15/20 at 5:32 a.m. documented the resident had been restless on night shift and as needed medications had been administered, staff provided one on one, with continuous redirection needed. The door motion alarm had been in reach of the resident on the wall next to the resident's bedroom door, and the resident pushed multiple buttons causing the panic alarm to trigger. Many residents were awakened and in response, they were wandering the hall or upset because Resident#13 had been wandering/lurking in the hall. At approximately 5:00 a.m. Resident#13 swung at staff while staff had been attempting to redirect the resident. Resident#13 had been standing in the doorway of	F 689		

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F 689	Continued From page 27 another resident's room. The Nurses Note dated 12/7/20 at 12:52 a.m. documented the resident had been elopement seeking that evening. The resident would lean into the doors long enough then they would open. Staff had repeatedly redirected the resident away from the door. The resident had hit staff members with a closed fist. One on one care had been done intermittently and required to prevent elopement. The primary care physician had been called with a message left for a request of medication for the residents behavior. The Nurses Note dated 12/7/20 at 4:01 a.m. documented the resident had been sent to the hospital at 3:50 a.m. per ambulance. The Nurses Note dated 12/7/20 at 10:35 a.m. documented the resident had been discharged from the emergency, and resident had departed at 10:30 a.m. with no new orders for the facility. The Physician Progress Note dated 12/8/20 at 9:27 a.m. documented the chief complaint as follows; resident had been seen in emergency department with aggressive behavior. Context documented; staff reported the resident seemed to have his days and nights mixed up. Staff reported that the resident sleeps a lot during the day and he is up most of the night. The resident had diagnoses of dementia with behaviors, with worsening since return from the emergency room. The Nurses Note dated 1/15/21 11:29 p.m. documented the resident displayed behaviors, such as combative behaviors toward staff when attempting to redirect the resident from entering	F 689		

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F 689	Continued From page 28 other residents rooms, refusing to stay in his own room, refusing to stay out of the nurses station or the copy room behind the nurses station. The resident would also yell at staff for physically ambulating next to him as a redirection intervention. The Nurses Note dated 1/17/21 at 11:23 p.m. documented that Resident#13 followed a female resident into her room. The resident had been redirected with some difficulty out of the room. Then Resident#13 became violent when asked to return to his room, he swung at the nurse twice, and advanced toward the nurse. The nurse grabbed both of the residents wrists, and both resident and nurse fell to the floor. The resident sustained a skin tear on the right forearm. The resident then calmed down, and a dressing had been placed on the skin tear. The Behavior Note dated 1/18/21 at 4:00 a.m. documented as follows; Resident#13 had not been found in his room. A search of the facility had been conducted, and the resident had not been found. The west door stop sign had been on the floor, and the alarm turned off. Search of grounds had been conducted twice with the resident found in a duplex sunroom sitting at a table with the lights off. The resident had been given a coat, and shoes then returned to the facility. The resident had an assessment temperature of 98.8 degrees Fahrenheit, feet warm and dry, skin warm, no new skin issues. The Nurses Note dated 1/18/21 at 6:30 a.m. documented the resident returned to his room, The Emergency Medical Tech and a facility nurse had assessed the resident. The residents feet had been warm, temperature 98.8 degrees	F 689		

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Fahrenheit, and the socks were dry.

During an interview on 1/27/21 at 10:07 a.m. Staff A, Registered Nurse (R.N.) reported he had been the night shift charge nurse on 1/17/21. Staff A reported Resident#13 had wandered all the time, and it can be hard to get him to stay in his room. Staff A reported the resident prefers to wear a shirt, long pants, and socks along with gripper socks. Staff A reported he had followed the resident into a room of a female resident. Staff A put an arm around Resident #13's waist to redirect him out of the room, then the resident swung at Staff A several times. Staff A reported he caught Resident#13's wrist, and they both fell. Staff A reported the resident did get a skin tear. Staff A stated the incident happened at about 11:30 p.m. on 1/17/21. Staff A reported the resident then went to wander in the lobby. Staff A reported he had been notified that Resident#13 had been missing at about 4:30 a.m. on 1/18/21. Staff A stated all the staff searched the building, which included the search of the basement, and the attached assisted living facility. Staff A stated he went down the west hall and noticed the velcro stop sign on the west door had been down, so he opened the door, the alarm did not sound. Staff A reported he saw footprints in the snow, and he followed them towards the condominiums west of the facility. Staff A reported he did open two storms doors to two of the condominiums but did not open the inner doors. Staff A reported the resident had actually been found in one of the condominiums sunrooms later on by another nurse who used her cell phone flashlight. Staff A stated the Emergency Medical Technician had checked over the resident as well as another facility staff member. Staff A reported he had been given education from the Director of

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F 689	Continued From page 30 Nursing on how the alarm is to be set. Staff A reported that now he does check the alarms to the west door every night. Staff A reported this had been the first time the resident had been out of the building. Staff A stated the resident would wander to the therapy area, lobby, and into other residents rooms. Staff A reported he had not been sure if the other nurses are checking the alarms on their shifts. Staff A stated the door alarms had not been part of the orientation, and he only does the door checks now because of Resident#13. Staff A stated Resident#13 had been at the front door to try to get out before. Staff A reported that he did not document the door checks. During an interview on 1/25/21 at 9:19 a.m. Staff B, Certified Nurses Aide (C.N.A) reported she worked the night shift (1/17/21 10:00 p.m. to 1/18/21 6:00 a.m.). Resident#13 had been in the main lobby, and had been upset. Staff B, reported she had given the resident some snacks, which seemed to help. Staff B reported at about 3:00 a.m. the resident headed back to his hallway. Staff B stated at 4:00 a.m. they noticed the resident had been missing, all the rooms had been searched, they found the key to the whirlpool room and unlocked it, searched the basement, and did not find the resident. Staff B reported the staff went to check the doors and noticed the west door alarm did not work, and saw footprints in the snow. Then followed them around on the sidewalk until the footprints stopped at a one story tan duplex west of the facility, the resident had been sitting in the sunroom of the duplex at a card table. Staff B reported that she put her shoes on the resident, and her coat, so they could walk the resident back inside the building. Staff B stated the resident had two pairs of socks on, long pants,	F 689		

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F 689	Continued From page 31 and a short sleeve shirt. Staff B reported Staff C, R.N. had been with her. Staff B this was her second night working at the facility, and the alarm looked like it had been off, she reported she did not know how it worked. Staff B stated now all the alarms are checked at the beginning of the shift, and the end of shift. Staff B reported the resident had been found at about 6:00 a.m., and that 911 had been called to help look for the resident. Staff B reported all the other doors had been working that night. Staff B stated the resident did walk a lot throughout the night shift. Staff B reported the west hallway had been the COVID-19 isolation hallway. During an interview on 1/25/21 at 12:35 p.m. Staff C, R.N. reported had worked the night shift on 1/17/21, and Resident#13 had behaviors earlier in the shift when wandering into a females room. Staff C stated it had not been uncommon for the resident to wander into other residents rooms or to hit staff, and he had been sent to the hospital before due to psychological issues. Staff C reported the resident had been aggressive towards other residents before, and that is why the staff would worry when he would go into other residents rooms. Resident #13 would follow other staff members around, for instance he would follow a nurse around when doing medication administration. Staff C reported that a good intervention for the resident had been snacks. Staff C reported the resident could give you and uneasy feeling, and will get into people's personal space. Staff C stated the resident had an altercation with a staff member earlier in the shift on the elopement night. Staff C reported the resident had been wandering around the west wing double doors (doors had been closed due to them leading to the COVID-19 unit), and had	F 689		

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F 689	Continued From page 32 attempted to get past the doors. Staff C reported the resident had been able to shut off his motion sensor alarm to his room, and would believe that he could shut off the alarm to the west door; the resident is able to read. Staff C reported the resident had last been seen at 3:30 a.m. prior to the elopement, at 4:00 a.m. the resident could not be found in his room and the staff immediately started looking, checking the building twice. Staff C reported they noticed the velcro stop sign had been down on the west door, and the alarm off. Staff C reported they followed footprints in the snow on the sidewalk outside the west door until they disappeared. Staff C stated she also drove around in her truck to look for the resident, and then went back to looking at the sidewalk. Staff C reported she had her flashlight on her cell phone, knocked on the door of sun porch attached to the condominiums west of the facility where she found the resident sitting in a chair. Staff C reported she found the resident close to 6:00 a.m., because the dietary staff that showed up to help us search started arriving at 5:30 a.m. for their shift. Staff C reported the resident had been wearing long flannel pants, a white t-shirt, and two pairs of socks. Staff C reported the emergency medical technician had assessed the resident, and there were no injuries. Staff C reported that they put warm clothing on the resident, and he continued to wander around the building. Staff C reported that they put three alarms on the west door, one of which is a motion alarm, and all the alarms are to be checked by the night shift. During an interview on 1/26/21 at 8:45 a.m. Staff D, R.N. reported she worked the day shift of 1/17/21, and that the maintenance staff are responsible for checking the door alarms. Staff D	F 689		

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stated Resident #13 wanders a lot, spends most of his time at the nurses station, and follows staff around. Staff D reported the resident likes to wear non-skid socks. Staff D reported the west wing is designated as the COVID-19 unit.

During an interview on 1/26/21 at 9:20 a.m. Staff E, Certified Medication Aide (C.M.A) reported the maintenance staff check the door alarms. Staff E stated Resident #13 can be aggressive towards staff, and his behavior can increase very quickly without warning. Staff E reported food is the best intervention for the resident. Staff E reported the resident had been sent to the emergency room for his behaviors. Staff E stated the resident could change the tone on his door alarm, but not sure, if he could have shut off the west door alarm.

During an interview on 1/26/21 at 10:19 a.m. Staff F, C.N.A reported the maintenance staff look after the exit doors. Staff F stated Resident#13 had touched the buttons on his bedroom door alarm; it is a good reminder for him to go back to bed when he hears it. Staff F reported the resident wanders, and does open exit doors.

During an interview on 1/26/21 at 2:17 p.m. Staff H, C.N.A reported the CNA's do not check the exit door alarms. Staff H stated Resident #13 had wandered a lot every day, and wears two pairs of socks.

During an interview on 1/26/21 at 2:50 p.m. Staff G, Assisted Director of Nursing (ADON) reported Resident#13 had been known to change the tone on his bedroom motion alarm. Staff G stated the resident had a history of exit seeking behaviors.

During an interview on 1/26/21 at 3:20 p.m. Staff

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F 689	Continued From page 34 J, C.N.A reported she worked the night shift. Staff J stated Resident#13 did change the tone on his bedroom alarm, and messed with the fire exit doors. Staff J reported the resident had worn two pairs of socks, the outer layer being gripper socks. Staff J reported the resident had calluses on his feet, and shoes hurt his feet, so he wore two pairs of socks. During an interview on 1/26/21 at 8:30 a.m. Staff K, Maintenance Supervisor stated after the elopement of Resident#13, a motion alarm had been added to the west door. Staff K reported that in the morning he would make sure that the door alarms sounded, and at the end of his day, he would visualize that the alarms are on and in place. During an interview on 1/27/21 at 11:47 a.m., the Director of Nursing (D.O.N) stated she had been notified at 5:15 a.m. on 1/18/21 that Resident #13 had been missing. The D.O.N reported she instructed the staff to check all the rooms, kitchen, chapel, and to look on the floor as he had a habit of laying on the floor. The D.O.N stated she had drove around the facility neighborhood, as she had not been far from the facility when she had been called. The D.O.N reported that she walked to the rooms, and opened the west door, foot prints had been in the snow, but did not have a flashlight, and the west door did not alarm when opened, the alarm had been off, and the velcro stop sign had been down. The D.O.N reported the staff had not been able to find him at 4:00 a.m., the last they had seen him had been when he headed west at 3:30 a.m., but staff did not say they saw him turn left towards south hall. The D.O.N reported the resident had been found by Staff C shortly after 6:00 a.m. and brought him in	F 689		

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the building. The D.O.N reported the resident had on two pairs of socks, long pants, and a long sleeve t-shirt. The D.O.N reported she had told night shift to check the alarms on nights. The D.O.N stated the motion alarm at the residents' bedroom door had been in place prior to the elopement. The D.O.N reported the west door exit is the only door that did not have a 15-second egress code alert. The D.O.N reported she had not been aware of a motion alarm that the facility administrator had put in place. The D.O.N stated the maintenance supervisor had been responsible for checking the door alarms on Mondays through Fridays twice a day.

During an interview on 1/27/21 at 9:36 a.m. the Administrator stated he had received, a call at 5:00 a.m. on 1/18/21 that Resident #13 had been missing from the facility. A building search had been done and one staff member had found footprints, staff had been searching on foot, one staff searching by car, and the west door alarm did not activate. The Administrator stated the D.O.N had called and reported the resident had been found, and had been checked over by the emergency medical technician, and the facility staff with no injuries reported. The Administrator reported that a motion sensor alarm had been added to the west door. The Administrator reported the nurses could carry a box with them that alerted them to when the motion alarm had been triggered. The Administrator reported the door alarms had been checked by the maintenance staff twice a day, but not on the weekends.

During an interview on 1/27/21 at 1:59 p.m. the 911 County Dispatcher reported that a 911 call had been made on 1/18/21 at 5:47 a.m. from the

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F 689	Continued From page 36 nursing home for the missing Resident#13. During an interview on 2/2/21 at 9:25 a.m., the state climatologist reported that on 1/18/21 at 3:30 a.m. the temperature had been 20 degrees Fahrenheit. During an observation on 1/27/21 at 1:21 p.m. the survey team picked up the motion sensor device off the floor next to the west exit door, the device flashed red occasionally. All the other alarms had been in functioning status per observation. The survey team continued to hold the motion sensor alarm, no staff responded for a total of ten minutes. During an observation on 1/27/21 at 1:33 p.m. the motion sensor alarm box had been located at the nurses station the #2 labeled west door had been flashing, no staff had been monitoring the motion sensor alarm box. The survey team took the box to the administrator. During an interview at 1/27/21 at 1:35 p.m., the Administrator reported he had not been sure why the box had not been sounding, and that the motion alarm is mostly for the night shift. The Administrator reported he had in-serviced Staff D, R.N. on the device, and someone else. During an interview on 1/27/21 at 1: 52 p.m., the Administrator and D.O.N reported and agreed that the motion alarm should have been active at all times, and the sound had been off. The Missing Resident/Elopement Policy dated 11/1/18 documented the unit charge nurse is responsible for knowing the location of their residents. The policy documented the	F 689		

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F 689	Continued From page 37 responsibility is for the charge nurse and all other staff. The Policy documented that at any time in which a resident is determined missing, the following procedure will be strictly followed: A. Alert: The supervisor/charge nurse will alert all other personnel by all paging "Code Gray" and location (including unit, floor and room number). B. Search; A search of the immediate area (building) will be initated under the director of nursing, shift supervisor/charge nurse. All rooms will be searched (including locked rooms). The nursing shift supervisor/charge nurse will designate staff to search the area surrounding the building, as appropriate (patio, parking areas, etc.) C. Contact: If the search of the immediate area (building) is unsuccessful, the nursing shift supervisor/charge nurse will immediately contact the: administrator and director of nursing, local police department, family/responsible representative, regional nurse and director of operations, attending physician, department of health notification as required. The Incident Description dated 1/18/21 documented as follows; the resident had not been found in room at 4:00 a.m... A search had been made of the building, every room, basement, and outside of the facility, and the resident could not be found. The Director of Nursing had been notified at 5:15 a.m., and arrived at the facility at 5:30 a.m. The room rounds had been completed again. Noted that the west door velcro stop sign had been on the floor, and the alarm had been turned off. Footsteps noted in snow on the sidewalk, and followed them until only sidewalk remained. Door to door search of duplexes done. Police notified when resident had not been found. Returned outside to check duplexes and found	F 689		

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PARKVIEW MANOR	516 THIRTEENTH STREET WELLMAN, IA 52356

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F 689	Continued From page 38 the resident at 6:15 a.m. in a sunroom in the dark sitting at a table. The resident had been given a coat and shoes and returned to the facility. A skin assessment completed. Vitals good. Body temperature 98.8 degrees Fahrenheit. No injures had been documented on the incident report. During an observation on 1/27/21 at 10:36 a.m. the west exit door of the facility to the location that the resident had been found (condominium sun room) included a sidewalk that went west out of the building, then turned south, then turned east, then turned west, for an approximate length of three hundred feet. The Logbook Documentation for test operation of doors and locks documented the west doors had been checked on 1/11/21 to 1/14/21 but not on 1/15/21. The facility was notified of the immediate jeopardy and given the IJ template on 1/27/21 at 3:45 p.m. The immediate jeopardy was removed on 1/28/21 as the facility provided education with all staff on monitoring residents at risk for elopement, elopement policy including notification of Administrator, DON and police, and ensuring door alarms are functioning. At the time of exit the scope and severity was lowered to a D.	F 689		

PLAN OF CORRECTION

Provider/Supplier Name:	Parkview of Wellman
Street Address, City, Zip:	516 13th Street Wellman, Iowa 52356
Date of Survey:	03/10/2021

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.	03/31/2021
	POC Date of 3/31/2021 except F689 which has a compliance date 1/28/2021	
F 551	**Rights Exercised by Resident Representative**	
	The resident representative has the right to exercise the rights of the resident. Parkview of Wellman treats the decisions of the resident representative as the decisions of the resident. The record review indicated notification to resident representatives did not occur timely.	
	Resident #6 is deceased. Resident #7 responsible party is notified with appointments, transfers & changes in condition. All resident with potential to be affected have been audited for Resident Representative notification, all are protected from occurrences via staff education and process changes.	
	Staff responsible for appointment set up and transferring of residents during acute condition changes have been education on process to ensure notification.	3/29/2021 thru 3/31/2021
	IDT Team will review transfers and appointments during routine meetings. QAPI team will review the auditing monthly for 2 quarters to ensure corrective actions are permanent.	
F573	**Rights to Access/Purchase Copies of Records**	

	The resident or resident representative has access to personal and medical records in a manner and form which they can understand and within 24 hours.	
	Resident #14 is deceased. Resident with potential to be affected are protected thru staff education and process changes.	
	IDT has received education on medical records process and follow up requirements.	3/29/2021
	Management Team will review medical records requests/completion of request during routine IDT meeting.	Ongoing
	Administrator or Designee will audit requests to ensure ongoing compliance. QAPI Meeting will review audits monthly x 4 quarters, then quarterly to ensure corrective actions are permanent.	
F686	**Treatment/Services to Prevent/Heal Pressure Ulcers**	
	The facility must ensure that that a resident receives care and service consistent with professional standards of practice to prevent pressure ulcers.	
	Resident # 4 no longer resides in the facility. Resident # 9 skin is intact. Resident#12 skin is intact. All residents with potential to be affected have been addressed thru staff education, weekly rounding by wound care physician, and partnership with Telligen on ongoing training opportunities for pressure ulcer care and prevention.	
	All residents received head to toe assessment for identification of skin integrity impairment.	3/10/2021
	Professional staff education on Wound Assessment, expectations & documentation	3/22/2021
	Placement of Wound Certified RN for weekly assessments and documentation	3/10/2021
	Change in Wound Care Physician	3/16/2021
	Telligen QIO for ongoing training opportunities for pressure ulcer care and prevention	Ongoing
	D.O.N/Wound Certified RN will monitor skin audits weekly to ensure problem does not recur. IDT Team will review weekly audits and admission skin assessments in routine meetings. QAPI team will review the auditing monthly for 4 quarters, then	

	quarterly to ensure corrective actions are permanent.	
F689	Parkview of Wellman ensures that the resident environment remains free of accidents hazards as possible	POC Date 1/27/2021 Abated 1/28/2021
	Resident #13 has interventions in place to prevent accidents. All Residents with the potential to be affected have been addressed thru staff education, repairs to facility equipment, care plan updates and ongoing auditing and monitoring.	
	Maintenance Director repaired West Exit Door Alarm Maintenance Director completed 100 % Audit of all exit door alarms to ensure functioning properly. SSD Reviewed and update elopement binder & completed 100% audit of all residents at risk for Elopement to ensure interventions in place. D.O.N completed 100% audit on all residents at risk for elopement and updated Care Plans & Kardex LNHA Administrator completed Elopement Drills x 3. LNHA completed in-service education with Maintenance Director on Inspection of Door Alarms Functioning daily D.O.N completed in-service education with Nursing Staff related to Monitoring residents at risk for elopement. All education has been incorporated into the New Hire Employee Orientation process	1/27/2021
	LNHA/Designee is auditing door alarm functioning 5 x weekly, D.O.N/Designee is completing Elopement Assessment and CP audits weekly x 4 weeks then monthly to ensure ongoing compliance. QAPI will review monitoring/Audits and Findings monthly x 4 quarters then quarterly to ensure corrective actions are permanent.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.