

Iowa Department of Inspections and Appeals
 Health Facilities Division
 Citation

Citation Number: #5405		Date: 10-11-21		
Facility Name: Salem Lutheran Home		Survey Dates: 9/7-28/21		
Facility Address/City/State/Zip 2027 College Avenue Elk Horn, IA 51531		SB		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

<p>58.28(3)e</p>	<p>481—58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)</p> <p>58.28(3) Resident safety.</p> <p>e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)</p> <p>DESCRIPTION:</p> <p>Based on observations, record review, staff and family interviews, the facility failed to provide adequate supervision and proper use of assistance devices to mitigate a resident's risk for elopement for 1 of 5 residents reviewed (Resident #1). On 8/31/21 at approximately 7:45 PM cognitively impaired Resident #1, with a history of wandering and elopement attempts, exited the building by following a visitor out the alarmed front door. Facility staff stated they assumed it was the visitor leaving and shut off the alarm. Staff stated they did not know the resident left the building. Approximately 20 minutes later, an off duty staff member observed the resident walking two and a half blocks south on Highway 173. The resident walked on the opposite side of the</p>	<p>I</p>	<p>\$7, 750 (Held In Suspension)</p>	<p>UPON RECEIPT</p>
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	<p>highway walking with his walker wearing shorts, a t-shirt and shoes. The off duty staff reported minimal traffic at the time she observed the resident. The weather was 71 degrees and no precipitation. The resident revealed he was looking for his wife to have supper with her at the pub and complained of feeling very tired. This resulted in immediate jeopardy for the facility. The facility reported a census of 49 residents.</p> <p>Findings include:</p> <p>1. The quarterly Minimum Data Set (MDS) I dated 8/24/21 identified Resident #1 with diagnoses that included: Alzheimer's disease, anemia, coronary artery disease, hypertension, diabetes, dementia, anxiety and depression. The MDS assessed the resident with a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive impairment). The resident required extensive assistance of 1 staff for dressing, bathing and toileting and required supervision with transfers and ambulation. The MDS revealed the resident fell since admission and identified his balance as not steady during transfer transition and walking.</p> <p>The Care Plan dated 5/10/19 identified Resident #1 with impaired cognitive function related to dementia. He required supervision with decisions. The care plan also revealed the resident had a</p>			
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	<p>potential for elopement last revised on 2/17/20 related to Alzheimer's disease as evidenced by the resident packing his belongings, attempting to leave the facility, talking about returning home and actually leaving the building.</p> <p>Progress Notes:</p> <p>On 7/11/21 at 4:10 PM the resident got out the first set of the exit doors at the kitchen but did not make it outside. He exited as a visitor came in. A nurse aide talked the resident back into the facility without further incident.</p> <p>On 7/13/21 at 10:02 PM earlier in the evening the resident had clothes, cheerios, and other belongings piled high on the seat of his walker. The resident was by the dining room and seated by the front door. Staff tried getting him to go back to his room and he refused saying he was going out that door, pointing to the front door, going to his brothers to get his truck. Staff tried to get him to go to the phone to talk to his wife and he refused. Another staff convinced the resident that his brother was going to be late coming to pick him up and he should wait in his room. The resident then walked back to his room and laid down in his bed.</p>			
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	<p>On 7/15/21 at 9:52 PM the resident was exit seeking and tried to go out the east entrance. When staff intervened, he became angry and threatened to hit staff. He stated he would break the door to leave. Staff got him back to his room.</p> <p>On 7/24/21 at 3:08 AM the resident was up wandering around and going into others rooms, turning lights on and scared another resident. Staff took him back to his room per a wheelchair as he resisted going to his room.</p> <p>On 7/31/21 at 11:50 PM the resident walked the halls with his walker and stated he planned to go buy beer. The resident kept pushing on the front door and did get the first door open sounding the alarm. It took four staff members to get him back to the nurse's station to call his wife. She did not answer so staff left a message for her. The resident sat at the nurse station for a while and then went back to his room.</p> <p>On 8/31/21 at 8:32 PM staff found the resident outside the facility. He returned to the facility with no injuries noted. The staff notified the physician and family.</p> <p>On 9/3/21 at 3:01 AM resident not sleeping well tonight and walked the halls.</p>			
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	<p>On 9/6/21 at 10:54 PM the resident came out of his room and stated he had things to do. Staff informed him everyone was in bed. He sat in the lounge for a while and then went back to his room.</p> <p>On 9/8/21 at 11:31 PM the resident used his tray table for support and pushed it out of his room and brought it into the nurses station. He stated would take the table out the door. Staff redirected him to his room but he returned to the hall pushing himself on his walker around the halls going into other residents rooms.</p> <p>On 9/13/21 at 9:48 PM the resident is awake and trying to leave the facility. He is looking for his wife and stated he's going to break out a window to get away from the facility if he has to.</p> <p>Administrator Interview Summary of Incident:</p> <p>On 9/7/21 at 2:20 PM the Administrator stated the evening of 8/31/21 there was a family member of another resident that set off the alarm to the main entrance when she brought her dad back into the facility. She immediately told a staff member that she set off the alarm and she added that she is now leaving in case she sets it off again. The Administrator stated one of the facility aides, Staff C certified nurse aide (CNA), lives next door, was</p>			
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	<p>off shift and out for an evening walk. The aide saw Resident #1 downtown across from the town pub walking on the sidewalk. Approximately 20 minutes lapsed from the time the main entrance door alarm sounded until the off duty aide saw the resident. The aide reported the resident was walking with his walker wearing shorts, a t-shirt and shoes. He told the off duty aide he planned to meet his wife for dinner at the pub but could not find her. He stated he felt very tired and denied injury. The Administrator stated it was 77 degrees outside with a light breeze and no precipitation. There were no restaurants or businesses open that night so there was not much traffic. The Administrator stated the aide took the resident back to the facility. Staff working reported they did not know the resident left the facility until the aide brought him back. The aide working Staff D CNA, assumed the door alarm that went off was the family member leaving so she silenced the alarm without looking to see if a resident left. Upon return to the facility, a nurse assessed the resident with no injuries found. The Administrator stated when he called and interviewed the family member, he asked about the possibility of Resident #1 following her outside. The family member stated she did see someone behind her but she didn't pay attention to who it was. The facility immediately hung signs for visitors to alert them to watch for residents behind them when</p>			
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	<p>they leave. They educated all staff on 9/1/21 on door alarm and elopement policy and procedures. He added that he also educated the family member involved and the Social Services Director followed up on the resident and his exit seeking behavior.</p> <p>Observations:</p> <p>Observation of care on 9/7/21 at 3:10 PM showed the court yard door opened and the door alarm sounded. Staff A CNA, immediately responded to the alarm. She stated it is facility policy that when a door alarm sounds they are to go to the panel on the wall and see which door it is. They then alert staff and go to that door to investigate who went out. If they do not find anyone outside the door, they are to start a resident head count and start full elopement procedure.</p> <p>On 9/7/21 at 3:15 PM Staff B stated as soon as a door alarm sounds they are to check the panel and see which door it is. They then go and check that door to see who went out. They are not to shut off the alarm until there is an all clear.</p> <p>Observation on 9/7/21 at 4:10 PM revealed the facility on the east side of highway 173 and the pub on the west side of highway 173. The pub is down a hill approximately 2 to 3 blocks south.</p>			
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	<p>The edge of town is 3 blocks farther south and the highway continues south with a gravel shoulder and corn fields on each side of the highway.</p> <p>Staff involved with the incident:</p> <p>On 9/8/21 at 12:32 PM with Staff C CNA stated she worked as a bath aide on day shift at the facility and worked at the facility for 17 years. She lives across the street from the facility and on the evening of 8/31/21 she stated she walked uphill going north on the highway that runs through town and saw the resident on the sidewalk in front of the pub approximately 2 ½ blocks from the facility walking downhill going south. She stated it was around dusk but not dark yet. She stated the resident was on the opposite side of the facility and wore shorts, a t-shirt and shoes. When she approached, the resident recognized her and told her he was looking for his wife because he planned to meet her for supper. He told her was okay and just very tired. She stated businesses close on Tuesday nights so there was not much traffic. Staff C stated there was a lady across the street that she knew and the lady came and assisted to get the resident into her car to take him back to the facility. Staff C stated she helped get him into the facility with the help of</p>			
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	<p>Staff D and then she left to go back home once she knew he was safe.</p> <p>On 9/8/21 at 1:00 PM with Staff D CNA stated she helped get the resident back into the facility. She stated the facility staff did not know the resident got out because all the staff working assumed it was a family member leaving. She stated the charge nurse told her a family member just left so she shut off the door alarm without checking for any residents outside. She stated she took the resident back to his room and helped him get ready for bed. He told her he had been on an adventure and felt very tired. She stated the facility trained all the staff the next day about elopement and door alarms.</p> <p>On 9/8/21 at 1:59 PM the Director of Nursing (DON) stated the highway the resident was found on is county highway 173 and the speed limit through town is 25 miles per hour.</p> <p>The Door Alarm Policy dated 5/7/19 documented:</p> <p>The staff member that answers the alarm at the alarm panel must double check to assure accuracy, which alarm is sounding prior to silencing the alarm.</p>			
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	<p>The alarm is not to be turned off until a staff member goes to the door and assures that a resident has not left the building. If a second staff member is available, the staff member silencing the alarm should direct the second staff member to page overhead, please check the west door, and please check the west door.</p> <p>This includes going outside to rule out elopement. If you see someone and are not sure who they are, please ask questions that will help determine if this is a resident or a guest. If no one is observed and staff is unable to verify who sounded the alarm, a resident head count must be completed to rule out elopement. If a resident is unaccounted for at head count, the elopement policy will be implemented. When it has been confirmed that the alarm was not an elopement, an all clear will be paged overhead so that all staff is aware that the alarm was answered and followed up appropriately. Once hearing the page, west door clear, west door clear, the alarm may be silenced.</p> <p>On 9/8/21 at 3:28 PM with Resident #2's daughter stated her dad is a resident at the facility. He wanted to go on a ride that evening and they returned to the facility. She stated she backed up to the facility to get him out of the car easier. She noticed she set the alarm off when she took him</p>			
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	<p>in so she let the nurse know it was her and that she was leaving in case the door alarm sounded again. She stated when she left she was upset because her dad was upset about her leaving him and she was in a hurry to leave. She stated she remembered seeing someone up by the front entrance but did not pay attention to who it was. As she left, she punched in the door code and went out. As she drove off, her car did not face the facility so she did not see if anyone followed her out. She stated it was possible someone followed her out. She stated the facility saw on camera that the resident followed her out. The facility called her and did training with her and she stated she will never let anyone follow her out again.</p> <p>Immediate Jeopardy Removal:</p> <p>The facility removed the immediate jeopardy on 9-1-21 after they hung signs for visitors to alert them to watch for residents behind them when they leave and educating all staff on 9/1/21 on door alarm and elopement policy and procedures. The facility also educated the family member involved and the Social Services Director followed up on the resident and his exit seeking behavior. Facility action to remove the immediate jeopardy resulted in past noncompliance. The</p>			
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	State Agency notified the facility of the immediate jeopardy on 9-9-21. FACILITY RESPONSE:			
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