Department of Inspections and Appeals
Health Facilities Division
Citation

Number: #5564				**Report Date:** February 2, 2022
Facility Name: Accura Healthcare of Pleasantville			**Survey Dates:** December 13, 2021 to January 6, 2022	
Facility Address: 909 North State Street	**VW JS**			
City: Pleasantville				

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
58.28(3)e	**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) **58.28(3)** *Resident safety.* *e.* Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) DESCPIPTION: Based on observations, record review and interviews, the facility failed to provide adequate supervision to prevent accidents for 4 of 4 residents reviewed for smoking, falls and elopement (Residents #9, #22, #26 and #29). The facility failed to assess resident for Resident #9 and #22 for safe smoking, allowed Resident #9 to carry smoking material on her person, allowed Resident #9 to smoke unsupervised, and allowed resident #9 and #22 to smoke in an unsafe environment. The facility failed to utilize a gait belt and front wheeled walker during ambulation for 1 of 3 residents reviewed for falls (Resident #26) which resulted in a femur fracture. The facility failed to provide adequate door alarm system to mitigate Resident #29's elopement. The door alarm contained modes to be set, one of which prevented the alarms from being activated at all times. On 10/14/21 at 1:30 a.m., Resident #29 eloped out the front door. At 2:40	**I**	**$8,250 (Held in Supsension)**	**Upon Receipt**

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	a.m., staff found Resident #29 outside on the ground. The facility identified 8 residents who demonstrated independent mobility and wandered on 10/14/21. Resident #29 was not one of the 8 residents identified by the facility. The facility reported a census of 43. Findings include: 1. SMOKING The MDS assessment tool, dated 9/28/21, listed Resident #9's BIMS as 14, out of 15, indicating intact cognition. Resident #9 had a diagnosis of asthma or chronic obstructive pulmonary disease (COPD), oxygen dependent and incontinence. Resident #9 is independent with bed mobility, transfers, and toileting; she requires set up assistance with eating. She is at risk for pressure ulcers. Clinical Record review of Care Plan, dated 10/11/21, revealed Resident #9, smokes on scheduled staff supervised smoke breaks and will go outside unsupervised to smoke. The Care Plan failed to address resident safety for independently smoking and the possessions of cigarettes and lighter quarterly and annually. Facility policy titled, Safe Smoking Policy, with the following dates of 12/28/12, 1/7/13, 8/7/14, 10/29/14, and 2/3/15 indicate Resident #9 is able to smoke independently. The policies failed to document Resident #9 cigarettes and lighter kept in her possession.			

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	During an interview on 12/13/21 at 11:00 a.m., with Resident #9 revealed, she is able to smoke outside independently anytime and does not follow the posted smoking breaks the other residents follow. During an observation on 12/15/21 at 10:13 a.m., Resident #9 demonstrated a cigarette case with four cigarettes and lighter in her possession. Resident #9 stated she was unsure if she signed a facility smoking consent or not. During an observation on 12/15/21 at 10:30 a.m., Resident #9 exited the facility to the courtyard covered in leaves. A pile of leaves by the door was approximately 2 feet in depth and within the cigarette butts receptacle. Resident #9 stated the leaves have been present for the past 1-2 years. During an interview on 12/21/21 at 11:13 a.m., with Assistant Director of Nursing (ADON) revealed Resident #9 may keep her cigarettes and lighter with her, documented on her smoking assessment. ADON stated Resident #9 might smoke at any time. ADON stated she did not know who was responsible to pick up leaves. 2. SMOKING The annual MDS dated 10/19/21 for Resident #22 reported a BIMS score of 7 which indicated sever cognitive impairment. The MDS documented diagnoses			

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	of non- Alzheimer's Dementia, asthma, chronic obstructive pulmonary disease or chronic lung disease and nicotine dependence (cigarettes). The MDS failed to document resident as a current tobacco user. Resident #22's Care Plan dated 11/16/20 included focus area of ADL (Activities of Daily Living) self-care deficit and potential respiratory abnormalities related to nicotine dependence. Included interventions for smoker and go out for routine smoking times with supervision from staff and cigarettes and lighter are stored with the nursing staff. The Care Plan also included an area of confusion due to dementia, amnesia, symbolic dysfunction and mild cognitive impairment and directed staff to monitor behavior and redirect as needed. The last documented Smoking Assessment dated 7/28/21 for Resident #22 included she had a cognitive loss, she smoked 2-5 times a day, she needed supervision and could not light her own cigarette and the facility stored her cigarettes and lighter. The facility failed to update the Smoking Assessment with the annual MDS. Observations revealed on 12/13/21 at 3:16 PM Resident #22 standing in the lobby to go outside to smoke. At 3:29 PM staff took residents out to smoke. Resident # 22 sitting in a chair spaced out 1 resident with apron on it. Staff have a lock box with the cigarettes in it. Area full of leaves by the fence and within feet of the red smoking receptacle.			

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	Observation on 12/14/21 at 9:42 AM, revealed the smoking area had fallen leaves swept off the patio area but piled up along the fence only about 3 feet from the red receptacle. During an interview on 12/27/21 at 1:44 PM with Staff A, Nurse Consultant, thought maintenance would be responsible for keeping the leaves out of the smoking area. During an interview on 12/27/21at 2:03 PM Staff G Maintenance stated he thought he was responsible for making sure the leaves were out of the smoking courtyard. He stated he had not moved any leaves for some time. The undated Resident Smoking Policy included the following: a. Smoking inside the facility is expressly prohibited. b. This policy applies to cigarettes, cigars, pipes and/or any other materials that requires fire. This also includes electronic or vapor cigarettes. c. A smoking evaluation with care plan interventions addressing safety issues must be completed upon admission quarterly, annually and for a change in condition assessments.			

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	d. A copy of this policy must be completed and signed by the resident and or the resident representative upon admission, and as needed which confirms understanding of the smoking policy and schedule. e. Following the completion of the smoking evaluation and acknowledgement of the policy, residents will be allowed to smoke in the designated smoking area with the supervision of a family member or other representative. No resident is authorized to smoke independently, they must be supervised by staff, family or another representative. When staff are providing supervision, smoking will only occur at times designated by the facility. f. The designated smoking area is the resident courtyard. g. All tobacco products including smoking tobacco, matches, lighters or other smoking paraphernalia will be kept by family members, or maintained by facility staff stored in a secure location. Residents may not sore smoking materials or supplies on person, in their belongings, or in their room, the reside twill be reevaluated and may not be allowed to continue smoking privilege id deemed unsafe. The facility will provide lighters to be used so residents do not need to purchase lighters. Residents are responsible to purchase all other smoking materials.			

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	h. Oxygen is prohibited in smoking areas for the safety of residents. i. Administrative/Clinical staff may also deny resident s the privilege to smoke for any other safety concerns such as inclement weather. j. At any time this it is deemed unsafe for the resident to be smoking, even with the use of interventions, he/she will not be allowed to do so. 3. FALL WITH FRACTURE A Minimum Data Set dated 9/14/21, documented that Resident #26's diagnoses included Alzheimer's disease, non-Alzheimer's disease, sepsis, and coronary artery disease. This resident's Brief Interview for Mental Status (BIMS) score was 03 out of 15, which indicated sever cognitive impairment. Resident #26 required extensive assist of 2 for bed mobility, transfer and ambulation. Resident did not ambulate in her room or in the corridor during the 7 day observation period assessed for the MDS. The resident used a wheelchair. In a Physical Therapy PT Evaluation and Plan of Treatment for Certification Period 10/4/21 to 12/29/21, documented a long term goal was that staff would be 100% compliant with the use of a forward wheeled walker when assisting patient for functional mobility for ADL's (Activities of Daily Living) and walk-to dines. The target date was 11/22/21. It documented that the			

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	equipment prior to onset was a forward wheeled walker. A Progress note dated 10/12/21 at 4:58 p.m., with a following Progress Note dated 10/12/21 at 5:08 p.m. that documented the progress note was from the incident on 10/5/21 at 9:30 a.m., stated that the nurse was called to the dining room and Resident #26 was lying on her left side on the floor. The CNA (Certified Nurse Aide) reported that the resident was ambulating in the hallway with the CNA and the resident started to lose her balance but the CNA was unable to reach the resident before falling. The Resident did complain of increased pain to the left knee and left hip area. A call was placed to the primary care provider and an x-ray was ordered. A Discharge Summary Final Report dated 10/12/21, documented the hospital course included: the patient (Resident #26) presented to the hospital as a transfer for left subcapital femur fracture. The patient was unable to say why she was there or the events that took place prior to her arrival. The patient complains of leg pain. Per the report (from the facility) the patient ambulated with a walker and had sustained a fall the day before. She was then sent to local Emergency Department after refusing to walk due to leg pain. CT (CAT scan) of pelvis showed non-displaced left femoral subcapital fracture. Patient's family was contacted and requested surgical intervention. Ortho was contacted and she underwent left femoral neck screw fixation on 10/7/21. She developed diarrhea and was positive for			

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	C-diff (bacteria). She was started on PO vancomycin (oral antibiotic) with stooling decreasing. Will return to nursing facility for ongoing rehab efforts. A Progress Note dated 10/12/21 at 2:30 p.m., documented that Resident #26 returned to the facility from the hospital via ambulance. The resident had a fractured left hip and was transferred to bed with assist of 3 people. An interview on 12/23/21 at 1:50 p.m., Staff DD, Registered Nurse (RN), stated that Staff Z, Certified Nurse Aide (CNA), shower aide, had walked Resident #26 from the shower to the coffee pot. Staff DD stated that Staff Z had walked Resident #26 a million times. Resident #26 had a shower and the two of them were walking from the shower. Staff DD stated that Staff Z and this resident had stopped at the coffee pot. She stated that another resident was there trying to get coffee and Staff Z intervened so the other resident wouldn't get burned. Staff DD stated that is when Resident #26 stumbled and fell. Staff DD stated she did not see the fall when it happened. Staff Z had went and got Staff DD directly after it had happened. Staff DD stated she did not know if a front wheeled walker was used as she didn't see the fall but stated that Resident #26 was independent. On 12/23/21 at 2:40 p.m., Staff Z stated that she had done the same routine with Resident #26 on Tuesdays and Fridays for the past 3 to 4 years before breakfast. She stated she always gave Resident #26 her shower			

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	and then they would stop at the coffee pot to get Resident #26 a cup of coffee. She stated that they always had gotten a cup of coffee for Resident #26 and then Resident #26 would sit down in the common area and drink it. On the day of the fall, Staff Z and Resident #26 had stopped at the coffee pot and when Staff Z was getting the cup of coffee, Resident #26 started side stepping and then fell down in slow motion. Staff Z stated she was unable to stop the fall even though she was close to the resident. Staff Z stated that it took 2 pumps to get the coffee and they literally had the same routine all those years, with Staff Z getting the coffee and Resident #26 standing beside her. Staff Z stated she did not hold on to resident when they walked but would stay close to Resident #26. Staff Z stated she never used a forward wheeled walker with the resident. Staff Z stated she should have used a gait belt on the resident though. Staff Z stated she felt horrible about Resident #26 getting hurt. Staff Z could not say what was on Resident #26's care plan or on the pocket care plan (at the time of this fall). Staff Z did not know that Resident #26 was care planned to use a forward wheeled walker. She stated that Physical Therapy may have been assisting this resident with the use of a forward wheeled walker. Staff Z said that the resident was acting per normal that day, the resident was not confused and her gait was per usual. Staff Z didn't feel this resident was dizzy or walking any differently than she had all along. Staff Z stated that since Resident #26's return from the hospital after the fracture, the resident is to use a walker with assist of 2 to ambulate to meals. Staff Z stated when Resident #26 first			

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	returned she required a Hoyer lift to transfer and was not ambulating. 1/03/22 at 4:05 PM, a message left for Staff S, Licensed Practical Nurse (LPN), requesting a call back. Staff S did not return the call. 1/03/22 at 4:08 PM, Staff N, Certified Medication Aide (CMA), stated she wasn't working the day Resident #26 fell and fractured her hip. Staff N stated she did not remember anything about it. Staff N stated that if my name was in the report that she was working and helped get resident up, she must have been working. Staff N stated the only thing she remembered Resident #26 needing help with before she came back from the hospital was going to the bathroom, changing clothes and walking out to meals. Staff N stated she did not remember if this resident had her walker back then. Staff N stated she would say probably prior to this resident went out to the hospital, staff would walk this resident with a gait belt. Staff N stated she did not even remember this resident falling and that was sad to say. Staff N stated there have been so many falls. Staff N added that if the resident did have a walker back then, Staff N would have used that too. On 1/4/22 at 8:28 AM, Staff CC, prior Nursing Home Administrator (NHA), stated she remembered there was confusion about the resident using a forward wheeled walker (FWW). Staff CC stated she no longer had access to the witness statement, but the witness told everything as it happened. Staff CC stated it sounded			

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	right that the CNA did not use a FWW. Staff CC remembered thinking that we didn't have an issue when she was first told about the fall. Staff CC did not remember who told her initially that there wasn't an issue but she remembered after talking with Staff Z, Staff Z did say the FWW wasn't used. Staff CC stated the care plan should have been followed and that was the subject of our conversation with Staff Z. Staff CC believed that Staff D, Nurse Consultant, would have been the one to follow up with Staff Z. Staff CC stated a thorough investigation took place and Staff CC and Staff D, Nurse Consultant, personally issued a warning to Staff Z for not following the care plan. On 1/4/22 at 9:17 AM, Staff D stated she had come to the facility a few days after Resident #26's fall. Staff D stated she did follow up with staff. Staff D stated Staff Z did not use the FWW nor did she use a gait belt. Staff D stated a gait belt should be used any time a resident requires more than supervision for ambulation. Staff D stated Staff Z did not follow the care plan and did receive discipline because of it. In an undated Witness Statement from Staff Z and was provided by Staff D, Staff Z had signed the following statement: On Tuesday October 5, 2021, she had showered the resident, ambulating resident to dining room table. At approximately 9:30 a.m., the resident and Staff Z stopped to get resident some coffee from the coffee bar that sits by the nurses station. The resident was			

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	standing next to her, independently without a gait belt on and Staff Z turned to get resident coffee. While she was obtaining resident's coffee the resident fell from a standing position. Then the resident went to take a step and she fell to floor. She was not using a walker at time of fall. Staff Z was aware that the resident was an assist of 2. Staff Z stayed with the resident until Staff DD came and assessed the resident. Staff DD and another staff member who she was unsure of, stood resident and placed her into a wheelchair. Staff Z stated that this was the resident's usual routine on her shower days (ambulate to dining room, gets a cup of coffee and then sits at table for breakfast). The resident was last toileted with her shower immediately prior to fall. The resident had not eaten breakfast yet. On 1/04/22 at 9:39 AM, Staff E, Certified Medication Aide (CMA), stated she had worked approximately 2 years at the facility and was familiar with Resident #26. Staff EE stated Resident #26 had been at the facility the whole time Staff EE had worked there. Staff EE stated that for the first couple of years she was at the facility, Resident #26 was independent. Staff EE stated Resident #26 then started needing more help with dressing and toileting and needed an assist of 1. Sometime, during that time, Physical Therapy (PT) gave Resident #26 a walker. Staff EE stated that sometimes the CNAs would walk with Resident with one CNA on each side of the resident to help her ambulate down the hall. When Resident #26 would use the walker she would run into the hall as this resident had never used the walker before and she would find it confusing and would			

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	periodically go without a walker. She's probably had the walker around 6 months. When she came back from the hospital she was initially a Hoyer transfer and was totally non weight bearing. Then she had to go back up to the surgeon to be released to moderate weight bearing. Now she is using a walker again and uses a gait belt. Staff EE stated the pocket care plan prior to resident's fall with fracture said that Resident #26 required an assist of 1 with a forward wheeled walker and gait belt. On 1/4/22 at 10:16 AM, Staff FF, Director of Rehab, stated she would look up Resident #26's information and then return the call. On 1/4/22 at 11:37 AM, Staff FF called back and stated Resident #26 was doing really well, and she's made really good progress. Staff FF stated that Resident #26 was getting back to herself which is really good and she isn't reporting any hip pain. Staff FF provided the following timeline: a. Resident #26 seen by PT from 9/2-17/21 and discharged with FWW with contact guard. Staff FF stated contact guard meant the resident was to have a gait belt on and a hand on or near the gait belt ready just in case she started to fall. Staff FF believed at that time she had an UTI and was hospitalized prior because of the UTI.			

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	b. On 9/24/21, OT (Occupational Therapy) was continuing on to address ongoing ADL weaknesses and activity tolerance and balance deficits. c. On 10/4/21, PT picked her back up for function and mobility. (Resident fell and fractured her hip on 10/5/21). d. On 10/14/21, back from hospital on skilled. Toe touch weight bearing with left hip-but was non-compliant so she was made a Hoyer lift transfer. e. On 10/29/21 PT discharged related to insurance. They recommended to continue with Hoyer transfer (lift into wheelchair or bed) until orthopedic follow up. f. On 11/22/21, returned to skilled care after her 6 week post op and updated to weight bearing as tolerated. She was to be seen for mobility and strengthening-deficits to address left lower strength, mobility, balance and strength. g. On 11/22/21 therapy indicated changed to assist of 2 for mobility and transfers. Minimum to moderate assist of 2 from sit to stand. Minimum to contact guard assist of 2 for mobility. Utilize FWW for all transfers and short distances in the room. Utilize wheelchair for longer distances such as room to dining room and room to shower.			

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	h. On 11/29/21, assist of 1 for all transfers, discontinue Hoyer lift transfer. Use FWW for all transfers and ambulate in room with FWW and assist of 2. i. Discharged on 12/10/21 with recommendations to continue under Part B. j. OT started 12/15 and PT started 12/17. Currently still on caseload. k. On 12/17/21, communicated assist of 1 with all transfers and gait belt with FWW. Ambulate to dining room with FWW and follow with the wheelchair as needed. l. On 12/23/21 discontinue with the wheelchair and do assist of 1 with FWW. 4. ELOPEMENT A MDS dated 10/10/21, documented diagnoses for Resident #29 included cancer, stroke, and non-Alzheimer's dementia. A BIMS score of 5 out of 15 indicated that resident had severe cognitive impairment. Limited assist of 1 was required for transfers, walking in room and corridor, and locomotion on and off the unit. A Witnessed Fall Report dated 10/14/21 documented that Resident #29 got up from the dining room table			

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	and walked to the front door and went outside. The CNA followed resident outside and tried to get him to come back inside. The resident refused and kept walking, stepped off the side of the concrete on to the grass where he fell, landing on his buttocks. CNA called for help via walkie and nurse went out to assess the resident. No hip rotation, no visible injuries. Resident denied pain or discomfort. After assessment completed, writer and CNA helped resident to stand up to his walker. Resident was able to walk with walker without reports of any discomfort. His range of motion was within normal limits. The resident was upset at staff for making him come back inside because he wanted to "leave in his car". An Elopement Risk Assessment dated 8/19/21 at 1:44 PM, scored resident at a 0 which indicated low risk for elopement. An Elopement Risk Assessment dated 10/14/21 at 9:45 AM, scored resident at a 3 which indicated high risk for elopement. A Focus area in Resident 29's care plan, documented that this resident was an elopement risk related to an actual elopement on 10/14/21. The goal was that the resident would not leave facility unattended through the review date. Interventions included this resident wore a Wanderguard, to check placement and function of Wanderguard as ordered, and medication review by the primary care provider.			

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	A Progress Note dated 10/14/21 at 2:27 AM, labelled this entry as a behavior note and documented that a staff CNA reported that the resident got up from the table and walked to the front door and went outside. The CNA followed the resident outside and tried to get him to come back inside. The resident refused and kept walking, stepped off the side of the concrete on to the grass where he fell, landing on his buttocks. The CNA called for help via a walkie and the nurse went out to assess the resident. No hip rotation, no visible injuries. Resident denied pain or discomfort. After the assessment was completed the writer and the CNA helped the resident to stand up to his walker. The resident was able to walk with walker without reports of any discomfort. Range of motion was within normal limits. The resident was upset with staff for making him come back inside because he wanted to "leave in his car." Fax was sent out to primary care provider and the Assistant Director of Nursing and administrator were aware. Progress Note dated 10/14/21 at 10:25 AM, documented that a Wander Guard was placed on resident's right ankle without any problems. This resident was friendly and compliant at the time. A Progress Note dated 10/14/21 at 10:30 AM, documented that a call was placed to this resident's daughter. She was made aware of the resident exiting the building and fell outside of the building. The resident was redirected into the building with staff			

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	assist and a FWW, without injury. No concerns voiced regarding resident exiting the building and fall. A Progress Note dated 10/15/2021 at 8:47, documented that resident's daughter returned a call to the facility and discussion was held regarding moving Resident #29 to the CCDI unit for elopement concerns per order from the primary care provider. The daughter was in agreement and voiced no concerns. A Progress Note dated 10/15/21 at 11:17 PM, documented that a call was placed to resident's daughter for further discussion regarding resident moving to the CCDI unit. Orders were received to discontinue resident transfer to CCDI unit after the Interdisciplinary Team reviewed. Resident's daughter was in agreement. On 12/13/21 at 1:26 PM, an observation revealed the CCDI (Chronic Confusion and Dementing Illness) unit door alarm sounded after the door was opened and before the door shut. Keypad on both sides of the door. The code was put in prior to the door being opened. On 12/14/21 at 3:30 PM, observation of exit doors revealed the following: a. A door alarm with an added pull string alarm was at the front door. Both Staff A and Staff D, stated the door alarm sounds differently for the WanderGuard then it does for people without a WanderGuard. The front			

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	door did not sound with the WanderGuard. Both the door and the pull alarm sounded but not a different sound for the WanderGuard. b. Checked doors at the end of the open unit hallways (north and south doors). Both sounded when opened. Both required a key code to disarm the alarm. c. Door to courtyard from the open unit was not locked nor did it alarm. The courtyard is enclosed. They leave the door unlocked year round. d. There was a door to a separate courtyard from the common area in the CCDI unit. This door was locked and would not open without entering a code. The code is written above the door. The door took some maneuvering by staff to get it to open after the code was put in. This courtyard was enclosed and paddle locks were noted on the gates. The fence is approximately 7 foot tall around both courtyards. e. The exit door down the resident room hallway on the CCDI unit sounded when opened. There was also a keypad on this door. f. There is a staff entrance door from the back parking lot. This required a code and will set off an alarm if door opened without the code. Staff D had a WanderGuard bracelet with her when checking the doors and this door sounded differently when the WanderGuard was close to the door.			

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	On 12/15/21 at 10:45 AM, Staff G, Maintenance Assistant, stated he was employed for 4 or 5 months. Staff G stated he was responsible for doing the checks on alarms, magnetic door locks, entries, exits, and the electric lock door in the infirmary. Staff G stated he had not had any issues with doors. He stated the doors had been getting a little old and finicky. Staff G stated they just went and replaced the alarms on the main door and the 2 North and South doors. A Work History Report printed on 10/14/21 at 8:51 PM, and provided by Staff G, showed the doors were check on 10/12/21 by Staff G. A Logbook Documentation, documented that on 10/12/21, Staff G tested the operation of doors and locks. The checks took 45 minutes. On 12/15/21 at 10:53 AM, Staff D stated the former NHA (Staff CC) had told Staff D that the front door alarm was set on the wrong setting. It was set to sound on day shift but not night shift. On 12/15/21 at 3:04 PM, voice message left for Staff CC, requested a call back. On 12/16/21 at 1:54 PM, Staff GG, CNA, stated she was working on the locked unit that night, so she was not working with Resident #29 but she heard about the incident. Staff GG stated there was only 1 CNA on the unlocked unit and that was Staff HH, CNA. Staff AA, Licensed Practical Nurse (LPN) was the nurse covering			

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	both units that night. Staff GG stated that Resident #29 had not tried to exit before when she had worked with him but she could see that he would do that, as at that time Resident #29 would walk up and down the hall. Staff GG stated she no longer works at the facility. Staff GG stated she had left the facility about 3 months prior to this interview. Staff GG stated there were a couple of resident who wore Wander guard in the front open unit. Staff GG was asked if she had heard an alarm go off that night, she was in the back (locked unit/CCDI) and didn't hear anything. She stated that there is usually an alarm that goes off and that was weird because there was not an alarm going off. The first story she heard was nobody knew how he got out there and the second story was that Staff HH had gone out there with the Resident #29. Staff GG stated the day before she had heard the front door alarm sound. She was working on second shift on that day, so it was working then. She did not know if someone messed with the alarm or not. 12/16/21 at 3:08 p.m., Staff II, Stanley Technical Support (contracted), stated he was contacted by the facility as the facility had an elopement for a resident who was not wearing a tag. He stated a tag is a Wanderguard device. The alarm at the facility was set on day mode. Staff II stated that the day mode does not refer to the time of day or a shift nor does the night mode. Staff II stated that when an alarm is set on day mode it will only sound when a resident with a tag opens the door. He stated if a resident not wearing a tag opened the door, when it was set on day mode, the			

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	alarm would not sound. Staff II stated he remotely changed the alarm from day mode to night mode. He stated when the system is set on night mode the alarm will sound every time the door is open without a code being entered no matter if a tag is worn or not. He stated that staff, visitors or residents with or without a tag would cause the alarm to sound if the door is opened without the code being punched in prior to opening the door. Staff II remotely changed the mode from day to night. The facility provided an email to Staff CC from Stanley Technical Support dated 10/14/21 at 1:59 PM which documented that this was a ticket update notification from Stanley systems. The ticket is closed. Should we mistakenly closed the ticket you can simply reply to this email with your comment or call us. On 12/20/21 at 3:27 PM, Staff AA, LPN- Staff GG stated she was having behaviors on the CCDI unit. Staff AA went down there and when Staff AA was coming back up the hallway from the unit, Staff HH had locked himself outside with Resident #29. Staff HH went outside to get Resident #29, and went out the front door and the doors lock behind him and they could not get back inside. Staff AA went outside and Resident #29 had fallen into the grass near the building. Staff AA assumed this resident fell because he was on different ground as he would have walked off of the cement. Staff AA helped get this resident up. The way Staff AA understood it was that Resident #29 walked out with Staff HH and that's when this resident fell. Staff AA			

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	stated that Staff HH was hard to understand. Staff AA stated that later it came out that Staff HH had watched Resident #29 go out the doors, but Staff HH was not with this resident when this resident went out the front door. Staff AA stated that it had been so long since she had heard the alarm. She stated they do not have a lot of people trying to get out the doors. Staff AA believed housekeeping checks the doors daily. Staff AA stated she was told there were issues with the doors before this incident happened. Staff AA stated the issue was the doors were not alarming if a resident was near the door or pushed the door open they. Staff AA stated the only doors that should make noise are the inside doors with Wanderguard. She stated the doors should alarm no matter what. Staff AA had heard administration knew about the doors not working but she did not believe that. Staff AA thought it was one of those deals that they would work part of the time and the part time that the doors alarmed would have been when family would come in and they would screen them before they could get through the interior doors. Staff AA stated if family would try to come in, it would set the door alarm off. Staff AA mainly worked day shift and then she worked night shift. Staff AA stated that is when she heard Resident #29 would wander some at night and she observed Resident #29 wandering. Staff AA stated one reason she had have chosen to not work PRN anymore is because Staff HH should never work alone. He was a good worker. They told me they would never put Staff HH alone up front, then that night happened. Staff AA stated she has not been back there since. Staff AA stated that at nights the nurse may have to go back			

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	to the CCDI and that would leave one CNA out there alone. She stated it was too much responsibility. Staff AA stated there were approximately 35 residents up front. She stated only resident that she dealt with that wandered at night was Resident #29. She stated she wanted to put Resident #29 in the back (CCDI) prior to him going out the front door. Staff AA stated she got an order for him to transfer to the back. Staff AA stated she was told you really can't move him to the back because it could agitate him more and could cause aggression in the back. Staff AA stated she did not remember it being cold or anything outside that night. Staff AA supposed it was maybe jacket weather. On 12/20/21 at 6:16 PM, Staff CC, former NHA, stated she remembered the incident but did not have access to her notes. The NHA stated she remembered in the beginning of the day, getting a message that Staff AA had left for her. The message had said that Staff HH had gone out the door with Resident #29. Staff CC stated that she then got to the facility and notified Staff D. Staff CC stated then Staff AA sent text messages and said the door alarm wasn't working. Staff D found Staff HH's witness statement on the copy machine around 11:30 AM-noon. The witness statement looked like Staff HH didn't see the resident go out the front door. Staff CC believed it was within 15-30 minutes from the time Staff HH last saw this resident to the time Staff HH found this resident. Staff CC believed that Staff HH had searched the building twice. Staff CC and Staff D immediately went over to the door. Staff CC stated that sure enough the alarm was not working. Staff CC stated			

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	the alarm wasn't working from the time that Staff HH discovered it until Staff CC read Staff AA's text around noon. Staff CC stated they put Resident #29 on checks and an assessment was done. Staff CC stated they reached out to Stanley who called back within a few hours. Staff CC immediately reset the door. It was on day mode and not night mode. Staff CC stated there was a difference about the day mode and night mode. Staff CC stated she set it on the night mode where it has a red button/light on it. Staff CC said their resource center had them call Stanley to be sure the alarm was functioning at that time. Staff CC stated she made a decision at the time to change the code because before it was a 3 digit code to open the door and the code that goes to night code was a 4 digit code with only one number off between the 2 codes. Staff CC talked with Stanley and Staff II checked and saw the alarm was working as designed. Staff CC could not change the 4 digit code per Stanley but could change the 3 digit code, so she changed it to 3 completely different numbers. Staff CC stated that her intuitive thinking took me there. Staff CC thought someone accidentally hit the 4th number, changing it from night mode to day mode. Staff CC stated the day mode activates WanderGuard. If it's in night mode it goes off anytime anyone opens it inside and out. There is a 3 digit code you can touch to shut off the alarm to get in and out of the door. The day/night code had 1 number difference otherwise 3 numbers were chronologically the same, if she was remembering correctly. Staff CC stated it should be on day mode for the WanderGuard to work, but the facility had always kept the front door on night mode. Staff CC			

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	stated the door would have been on day mode when the resident eloped. The resident did not wear/was not care planned for a WanderGuard device at the time of the elopement. Staff CC stated she did not like the design. If the color is red on the alarm, that means it will always alarm when the door is opened (night mode). It won't detect a WanderGuard. It will just sound whether a resident or non-resident is wearing a WanderGuard or not. She stated the code is on the inside of the staff entrance (a different door), up high. This door is on day mode but is locked so a code is required to go through the door at any time and will alarm if the door is opened and the code wasn't punched in first. The day mode and night mode do not correlate to the time of day. 1/04/22 at 8:28 AM, Staff CC stated she submitted an email report to DIA initially within 24 hours for the elopement. On 12/21/21 at 10:02 PM, Staff HH stated Resident #29 sometimes came out of his room to hang out in the dining room. Staff HH stated Resident 29 would get up and sometimes sit in the couch or chair in the common area. Staff HH stated he did not have good peripheral vision. Staff HH got up to start rounds and Resident #29 was at one of the tables and he was walking toward the door and Staff HH thought he was going to one of the seating areas where Resident #29 sometimes sits. Staff HH was charting when Resident #29 was walking toward the seating. Staff HH stated it was about 1:30 or 2:00 AM. Staff HH wrote a little report so that should be more accurate. Staff HH was sitting at a table behind			

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	this resident when this resident walked toward the couch. Staff HH didn't even think Resident #29 would go out the door. Staff HH stated Resident #29 had never tried to go outside or never said he was going to go outside. Staff HH stated that Resident #29 was not exit seeking. Staff HH was charting and Resident #29 was out of Staff HH's line of sight. Staff HH stated that he was going to start his rounds but then intuition kicked in and he thought he'd better check on Resident #29. Staff HH stated Resident #29 was not over in either seating area. Staff HH stated he checked the halls and Resident #29's room and other resident's rooms and could not find Resident #29. Staff HH stated he did that twice. Staff HH stated he then walked outside to see if he had gone out there. Staff HH had his walkie with him. Staff HH stated that Resident #29 had walked down the side of the building and Staff HH found Resident #29 sitting on the grass. Staff HH stated he thought this resident was trying to stand up. Staff HH stated he tried the walkie a couple of times, but it must have been out of reach. Staff HH then tried to go inside but the door was locked. Staff HH stated he used his cell phone to call the facility and Staff AA answered the phone. Staff HH stated that Staff AA came out and she made sure the door was not going to lock on them. Staff HH stated that they both walked out and assessed Resident #29. Staff HH stated Resident #29 was rubbing his right knee a little bit and this resident's knee was slightly red. Staff HH then stated there might have been some redness. Staff HH stated they helped Resident #29 to stand up. Staff HH and Staff AA then walked Resident #29 inside and Resident #29 did say something			

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	about his car. Staff HH stated they told Resident #29 his daughter was taking care of his car, she had taken it to the shop and Resident #29 calmed down. Staff HH stated Resident #29 was just slightly agitated about his car and Resident #29 wasn't hurt. Staff HH stated that Resident #29 had never asked about his car before. Staff HH stated that he and Staff AA then realized the door alarm didn't work. Staff HH stated he and Staff AA took Resident #29 back to bed and he was totally fine the rest of the night. Staff HH stated that Resident #29 said he wasn't hurting. Staff HH stated he made sure Resident was still in bed as he kept peeking in there at this resident. Staff HH stated this resident fell where the concrete ended, where all the chairs are at when you turn right when you go out the front door. Staff HH stated this resident did not fall down the hill. Staff HH stated there is a little hill out there. Staff HH believed the nurse at least checked on the alarm to see why it didn't go off. Staff HH had asked her to check to make sure that he just didn't hear it go off. Staff HH was later told that he should have had the nurse initiate the search and not him. Staff HH stated he only started looking for Resident #29 because the nurse was in the back in the unit. Staff HH stated he understood why he should have had the nurse initiate the search as he had locked himself out. Staff HH stated he was hard of hearing. Staff HH stated it was just Staff AA, himself and then whoever was in the Lodge (CCDI) the night this resident went outside. Staff HH stated that back then he was normally working with just one nurse and then a CNA was in the back. He stated that now they normally have 2 CNAs. Staff HH the alarm has been working			

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	since then. A resident pushed on the door when she was wandering around and the alarm sounded. Staff HH stated he heard it. Staff HH stated that Resident #29 and another resident are up at nights. Staff HH stated that the weather was mild outside that night. He stated it wasn't like freezing, it wasn't cold because he would have grabbed a coat prior to going outside. Staff HH stated it was about 15 minutes from when he last saw Resident #29 walking toward the front seating area to when he found him outside. An Investigation Questions form documented the date/time of the incident was 10/14/21 at 1:30 PM, and documented that Staff CC and Staff D interviewed Staff GG. Staff GG had not heard anything about the incident until after the shift. What Staff GG heard was Staff AA had told her that while she was busy, Resident #29 was outside with Staff HH. Staff GG stated she did hear Staff HH paging, saying something like repeating Staff AA's name and saying best friend or buddy? He did not indicate an emergency. Staff GG was in the lodge (CCDI) unit doing rounds. She did not assist with the incident as at the time she did not know what was going on. Staff GG asked if Staff HH followed Resident #29 out the door, that wouldn't be an elopement, would it? Staff GG stated she had heard that Staff HH had followed the resident out the door. Staff B signed the form on 10/14/21 at 2:02 PM. Staff CC signed the form at 10/14/21 at 4:02 PM. An Investigation Questions form documented the date/time of the incident was 10/14/21 at 2:27 PM, and			

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	documented that Staff CC and Staff D interviewed Staff AA. Staff AA stated that Staff HH stated that a resident went out the front door. Staff HH stated he was "right on his tail" and Staff HH tried to get resident back into the building, resident was difficult to redirect and fell with his walker. Staff CC documented that Staff HH called the facility from outside the front door had been and that she did not witness the incident. Staff AA stated she walked to the front of the building from the CCDI unit and the phone was ringing. Staff HH was on the phone stating that he was out front of building with resident and they were locked out. Staff AA had been on the CCDI unit putting away medications from pharmacy delivery. Staff AA assisted resident back into the facility after identified there were no injuries. Staff AA completed a head to toe assessment and took vital signs. Staff AA notified Staff CC and the Assistant Director of Nursing of the incident and door alarm not sounding. Staff AA sent a fax to the primary care provider. Staff AA reported that Staff HH had told her that the resident got up from a recliner chair and went to the door. Staff B signed the form on 10/14/21 at 3:45 PM. Staff CC signed the form on 10/14/21. An Investigation Questions form documented the date and time of the incident was 10/14/21 at 1:30 AM, and documented that Staff B and Staff CC were the interviewers. Staff HH reported that he did not hear anything but noticed that Resident #29 had got up from the table and walked away. Staff HH thought the resident was going to sit on one of the couches and when he checked on the resident, the resident wasn't			

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	there. Staff HH reported he searched every room twice and went out the front door to look as he did not hear an alarm. When Staff HH checked outside he saw Resident #29 on the ground. Staff HH reported it to the charge nurse. Staff B and Staff CC did not sign or date the form. An email from the State Climatologist of Iowa and dated 12/21/21 at 9:29 AM, documented the weather in that area on 10/14/21 at 2:40 AM, was as follows: Temperature: 54 degrees Fahrenheit Relative humidity: 62% Winds out of the WSW at 6 mph Overcast skies No precipitation detected No wind chill temperature A Resident with Wander Guard list provided by the facility during the survey named the following residents to have Wander Guard devices and the date they were placed: a. On 10/9/21, Resident #12. b. On 4/30/21, Resident #41. c. On 1014/21, Resident #29. The facility provided a list of 8 residents who demonstrated independent mobility and wandered on 10/14/21.			

If, within thirty (30) days of the receipt of the citation, you: (1) do not request a formal hearing or; (2) withdraw your request for formal hearing; and (3) pay the penalty, the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Administrator Date

Department of Inspections and Appeals
Health Facilities Division
Citation

Number: #5564				**Report Date:** February 2, 2022
Facility Name: Accura Healthcare of Pleasantville			**Survey Dates:** December 13, 2021 to January 6, 2022	
Facility Address: 909 North State Street	**VW JS**			
City: Pleasantville				
Rule or Code Section	Nature of Violation	**Class**	**Fine Amount**	**Correction Date**
	On 10/14/21, the facility implemented the following: a. A secondary alarm to the front door. b. Changed the door code to prevent staff from being able to change the door modes and ensure it remains active at all times. c. All staff received education on missing resident process and process for non-functioning door alarms. d. An audit of all exit doors and door alarms to ensure proper function. e. An elopement drill conducted with all staff on shift. f. Plan to continue elopement drills once a week to ensure compliance for 4 weeks and then monthly. g. All residents reviewed for elopement risk and appropriate interventions put into place. h. Facility to audit for proper functioning door alarms every shift for 14 days and then daily to ensure continued compliance. FACITITY RESPONSE:			

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