Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **#5353**			**Date:** **8/17/21**
Facility Name: **Accura Healthcare of Manning**		**Survey Dates:** **7/13-8/3/21**	
Facility Address/City/State/Zip **402 Main Street** **Manning IA 51455**			
	SB		

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) **DESCRIPTION:** Based on observation, staff interviews and record review the facility failed to provide adequate supervision and assistance devices to residents at risk for falls, and failed to establish reliable precautions and systems to prevent residents from exiting the building unattended for 7 out 15 residents reviewed. On 7/18/21 staff left Resident #10 (a resident known to make self transfer attempts) sitting on the side of the bed after the resident activated their motion alarm indicating movement from bed and knowing the resident needed the toilet. After staff left the resident, the resident attempted to self transfer and fell face-down, suffering from a major head injury. The resident expired 4 days later. On 7/31/21 an	**I**	**$8,000**	**Upon receipt**

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	untrained environmental aide attempted to transfer Resident #15 and the resident fell to the floor. Residents #7 and #8 wore elopement bracelet devices and alarms failed to function when the residents exited the building unattended. In an observation on 7/20/21, Resident #11 transferred himself to the bathroom. According to staff, Resident #11 should use a bed alarm. The bed alarm was not in place at the time of observation. Residents #8, #12, and #14 wore expired elopement bracelet devices at the time of the survey. On 7/13/21 the alarm to the front door of the facility was turned off, and staff reported they have difficulty hearing the door alarms when they are in a room with a resident and the door is closed. Observation on 7/20/21 at 10:30 PM revealed two medication carts unlocked and unattended. The facility reported a census of 36 residents. Findings include: 1. A Minimum Data Set (MDS) dated 6/9/21 assessed Resident #10 with a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognitive ability. The MDS showed the resident required limited assistance of one staff for transferring, toileting, walking and bed mobility. The MDS identified the resident as not steady and only able to stabilize with staff			

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	assistance when moving from seating to standing and from surface to surface. The MDS indicated that the resident had a motion sensor alarm used daily. The care plan revealed the resident initially admitted to the facility on 9/25/15 with diagnoses that included: congestive heart failure, iron deficiency, overactive bladder and cancer. The care plan included a focus area of risk for falls initiated on 10/8/15. The care plan revealed the resident would not use the call light to alert staff of needs and the resident would attempt to self ambulate and transfer. The Director of Nursing (DON) updated the care plan on 7/20/21 and identified the resident at risk for falls due to low hemoglobin levels and no longer wanting to treat the condition. A care plan intervention dated 6/12/21 revealed the resident used a motion alarm in the room and directed staff to place the alarm on the floor near the dresser so the alarm didn't detect every time the resident moved around in the chair and would only activate when the resident attempted to get up without assistance. The care plan did not include the intervention for a pressure alarm in the bed until 7/18/21.			

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	The care plan included a focus area of impaired cognitive functioning and impaired thought processes initiated on 6/12/21 that indicated the resident was experiencing gradual decline in cognitive ability. On 6/2/21 pain medication was added to the care plan and staff were instructed to monitor for upper GI bleed. The care plan indicated that the resident had a cancerous mass on the pancreas and suffered with abdominal pain. On 6/21/21 the care plan included an intervention to monitor for side effects to antianxiety medication such as drowsiness and blurry vision. The Medication Administration Record (MAR) for the month of July 2021, revealed on 7/17/21 at 9:00 PM the resident received two medications known to cause drowsiness; Remeron (antidepressant) 15 milligrams (mg) and Tramadol (narcotic) 50 mg. Information on Tramadol and Remeron was retrieved on 8/3/21 at 8:03 AM from https://www.drugs.com. The web site showed that common side effects of Tramadol were dizziness, drowsiness and tiredness. Common side effects of Remeron included dizziness and drowsiness. A fall risk assessment dated 6/8/21 showed Resident #10 could not come to a standing			

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	position on her own and required hands on assistance to move from place to place. An incident report dated 7/18/21 at 5:15 a.m. and completed by Staff C LPN (licensed practical nurse) identified an unwitnessed fall in the resident's room. The report revealed at 5:15 a.m. the resident's alarm activated and staff observed the resident sitting on the side of the bed. The resident needed the bathroom. The resident did not use the call light. Staff left the resident seated at the bedside to get a mechanical lift located across the hall. When staff arrived back to the room with the lift, staff found the resident face down on the floor on their stomach with blood under her head. Staff used a bath blanket for the blood and to apply pressure. The nurse aide called 911. The resident said her head hurt and denied other pain. The ambulance arrived at 5:32 a.m. EMTs (emergency medical technicians) applied a back board and collar before placing the resident on the gurney. At that time, staff observed 2 lacerations to the right side of the resident's head and the resident's right eye turning purple. The largest of the lacerations appeared circle shaped and about the size of a nickel. Abrasions were observed to both knees. The description of the incident was: resident needed the bathroom. The resident's mental status described as: oriented to person and place			

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	and in the notes section, Staff C documented the resident attempted to ambulate independently when staff went to get the EZ stand mechanical lift. The report identified the resident's predisposing physiological factors as: gait imbalance and impaired memory. The predisposing situational factors identified as: ambulating without assistance. The report asked if this predisposing factor contributed to the fall and Staff C answered "YES". The report identified the resident as too weal to transfer and ambulate without assistance. The report did not identify when staff last saw and/or toileted the resident or if the call light was available. An Emergency Department (ED) report dated 7/18/21 at 6:32 AM revealed the Resident #10 was found on the floor in his/her room at the facility with head face down and presented to the ED with lacerations and a small hematoma on right forehead, ecchymosis and swelling to right eye, ecchymosis and swelling on bilateral knees, and was only able to verbalize pain and mumbled incoherently. The ED staff were unsure of the resident's neurological baseline, but at the time of the exam, the resident was not oriented to self, time or place. The ED report dated July 18 at 7:50 AM indicated that the resident suffered a major injury and ED			

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	sent the resident back to the facility with comfort care services. According to an untimed statement dated 7/18/21, Staff W assisted the roommate of Resident #10 at approximately 5:00 AM on 7/18/21 when the bed alarm sounded from Resident #10's side of the room. Staff W said the resident was in bed and Staff W turned off the alarm and told the resident that staff would be right back to help and continued to assist the roommate. Staff W said that Resident #10 sat up in bed and put his/her feet on the floor. Staff W asked the resident to stay seated while staff went across the hall to get the mechanical lift and the resident responded "okay." Staff W said that upon reentering the room, staff observed Resident #10 lying face down on the floor with blood around her head. Staff W then called for the nurse on duty. When the nurse arrived in the room, Staff W called 911 and the resident transferred to the ED shortly thereafter. On 7/19/21 at 4:45 PM Staff C LPN identified himself as the nurse on the overnight shift 6:00 PM- 6:00 AM on 7/17/21 when Resident #10 fell. Staff C said that the aide assisted Resident #10's roommate when Resident #10 sat up on the edge of her bed. The aide told the resident to wait while she went to get the lift from across the hallway			

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	and would be right back. When the aide came back into the room, the resident was face down on the floor by her bed. Staff C said that he did not know why the aide thought she needed the lift because the resident was known to require on staff to assist her. Staff C revealed three staff worked on the night of 7/17/21 but one aide had to leave at 4:00 AM, leaving just two staff on at the time of the fall. Staff W Certified Nursing Assistant (CNA) went into the room alone while Staff C helped another resident. Staff W was in with the resident and that the lift located in a room across the hallway. Staff C said that they typically have two aides on overnight but they went through a stretch of time with just two staff because of someone calling in sick. On 7/21/21 at 9:00 AM Staff W CNA stated she worked for a staffing agency and worked at the facility about 10 times before the night of the fall. Staff W said there was report given before the shift started regarding any changes in status or condition of the residents and Staff W did not know of any changes with Resident #10 on 7/17/21. Staff W said she assisted the roommate of Resident #10 around 5:00 AM on 7/18/21 when			

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	the alarm for Resident #10 started ringing. Staff W said she turned the alarm off and told the resident to wait and the resident responded that she would wait. Staff W said the resident always listened and would wait when asked. Staff W said that it would have been good to have another aide there at that moment because it was just two staff on at that time and other call lights were ringing. Staff W said that Resident #10 laid in bed and said she needed to use the bathroom and sat up on the edge of the bed. The alarm activated again and the resident sat on the bed with feet on the floor and appeared drowsy. Staff W said that the resident responded when asked to wait for the lift. Staff W stated the last couple of times she worked at the facility, staff told her in shift report that the resident used the mechanical sit-to-stand at night because of increased weakness at night. Staff W said she had used the stand with Resident #10 3 or 4 times before that night. Staff W said she operated the EZ stand alone and did not know facility policy regarding how many staff needed to be present when using the stand. Staff W said she felt comfortable using the EZ stand alone with Resident #10 because the resident could stand up straight on the platform.			

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	According to the following nursing notes the resident experienced some anxiety and restlessness leading up to the fall: a) 6/29/21 at 10:06 AM trying to crawl out of bed and self-transfer b) 6/29/21 at 9:49 PM restless and trying to leave the facility c) 6/30/21 at 9:37 PM restless tonight d) 7/4/21 1:16 PM restless e) 7/11/21 at 11:23 AM attempting to stand up from the wheel chair f) 7/11/21 at 6:28 PM increased anxiety, attempting to take off clothes g) 7/15/21 at 4:47 PM increased anxiety and restlessness h) 7/17/21 at 10:32 AM restless On 7/20/21 at 10:30 PM Staff Q LPN stated Resident #10 could sit up in bed but was not strong enough to stay up on her own. Staff Q said that he/she would not have turned his/her back on the resident or let the resident alone sitting on the side of the bed. Staff Q said that the resident would listen when given directives, but recently needed the use of the mechanical lift for transfers because of increased weakness. On 7/20/21 at 9:17 AM the Director of Nursing (DON) stated the facility implemented what she			

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	called a "falling star" system where they put a star on the door frame to alert staff that the resident in that room could not be left in a wheel chair unattended in their room. The DON said they did this because "obviously we have a fall problems." The surveyor asked if she thought the number of falls may be related to not having enough staff. She acknowledged that it could be and said that they have trouble getting people to work the overnight shift. She said when Resident #10 fell they had just two people here for a couple of hours because someone called in, unable to come to work. When asked why the aide went to get the lift when the care plan indicated Resident #10 was a transfer assist of one, the DON said she did not know and she asked Staff C LPN and he said maybe it was because the resident had recently become weaker. On 7/27/21 at 10:20 AM the DON said that they do not have a policy on the use of the EZ stand but per corporation guidelines, all mechanical lifts must be an assist of 2 people. A Major Injury Determination Form signed by the physician 7/18/21 at 7:50 a.m. informed the physician the resident self transferred an fell hitting the floor. The form identified the resident used a lift at night due to weakness and 1 to 2 staff assistance during the day. The physician			

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	documented the injury the resident sustained from the fall was a large intraparenchymal hemorrhage in the right cerebral hemisphere and identified the injury as a MAJOR injury. The hospital report dated 7/18/21 revealed a CT performed showed a large intraparenchymal hemorrhage in the right cerebral hemisphere, predominantly in the right parietal lobe with associated local mass effect, resulting in effacement of the right lateral ventricle and approximately 1.6 centimeter (cm.) shift. The laceration to the right forehead was repaired with sutures. X-rays of the knees were done. The report identified the resident as awake but not oriented in any sphere. The resident had a hematoma to the right forehead, ecchymosis and swelling to the right eye. The physician could not examine the eye due to inability to open the eyelid because of ecchymosis and swelling. The left pupil was fixed and non reactive to light. Strength and sensation could not be assessed since resident could not follow commands. The resident expired 7/22/21. 2. An MDS dated 7/8/21 assessed Resident #15 with a BIMS score of 15 (no cognitive impairment). The resident required extensive assistance of one staff for transfers, locomotion,			

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	dressing and toileting. According to the census tab in the electronic chart, Resident #15 admitted to the facility on 6/11/21. The care plan for Resident #15 dated 6/11/21 included a focus area of risk for falls due to a history of a cerebrovascular accident (CVA) with right sided weakness. The care plan identified the resident with an activities of daily living deficit due to CVA and limited range of motion of the right hand and elbow and a contracture to right shoulder. The care plan included diagnoses of: hemiplegia and hemiparesis following CVA, muscle weakness and chronic kidney disease. An incident report dated 7/31/21 at 7:36 PM, at approximately 4:30 PM on that date, revealed a CNA reported to the registered nurse (RN) on duty that Staff BB environmental aide (EA), attempted to transfer Resident #15 and the resident fell. The report revealed the resident told the RN that the EA attempted to transfer her from the recliner to the wheelchair and the EA's feet got tangled up and the resident was lowered to the floor. On 8/2/21 at 11:50 AM a nurse from the office of the primary care physician said they did not receive notification of a fall over the weekend for Resident #15. The nurse said communication			

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	regarding a fall without injury would typically come in via fax and she was not aware of any, but would check with the doctor to see if he got a call. At 11:57 AM the physician's nurse called and reported the doctor did not receive notification of a fall for Resident #15 over the weekend. On 8/2/21 at 1:12 PM the Director of Nursing (DON) said she had been informed of the fall over the weekend but she did not know that the doctor nor the family did not receive notification. She said when she saw the incident report on Monday morning she then contacted the family. The DON said that Staff BB came in on Monday morning and a received a disciplinary action report. On 8/2/21 at 1:35 PM Staff DD (business manager) stated the only corrective action form completed for Staff BB completed on that day and she had no other incidences of concern. On 8/2/21 at 2:18 PM Resident #15 was hesitant to talk to about the fall. She said it was nothing and she did not get hurt. The resident said that she activated her call light, but she did not want to give any details of the incident. On 8/2/21 at 12:20 Staff EE RN stated she worked for an agency but worked at the facility for about a month. Staff EE stated she passed			

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	medications on Saturday afternoon, 7/31/21 when around 4:30, a CNA came to the nurses station and asked for the vitals equipment. She asked why the CNA needed it she said an EA staff transferred a resident and the EA got her feet tangled up and the resident fell. Staff EE said she went along and completed an assessment on the resident and found no injuries and vitals within normal limits. Staff EE remembered the resident expressed concern the EA would get in trouble. Staff EE said she notified the Assistant Director of Nursing (ADON) and was told that since the EA lowered the resident to the floor, she would not count it as a fall. Staff EE said that the ADON's directions were to just put in a nursing note that the resident had been lowered to the floor. Staff EE said that she was concerned that an incident report risk management form should have completed so she consulted with Staff C who arrived for the 6:00 PM shift. Staff EE said that Staff C recommended she go ahead and complete an incident report so Staff EE decided to complete one. Staff EE said the ADON would talk to the DON about the incident and Staff EE thought they would then decide about doctor and family contact. On 8/3/21 at 9:17 AM Staff C LPN stated he arrived for the evening shift on 7/31/21 and Staff			

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	EE informed him of the directive she received to just enter a progress note regarding the fall. Staff C advised Staff EE to complete a risk management form and assisted with that task. Staff C said that he advised that if it were him, an incident report would be filled out. On 8/2/21 at 3:00 PM Staff GG CNA said he charted in the nurses station when Staff E Certified Medication Aide (CMA) asked him to go help Staff BB EA with Resident #15's transfer. Staff GG stated Staff BB helped around the facility throughout the shift and he thought Staff BB was a CNA. When Staff GG got to the resident's hallway, he saw Staff BB in the hallway crying, saying she didn't know what to do. Staff GG went into the resident's room and observed the resident on the floor by her recliner. The resident's bottom was on the floor and she leaned up against the wheel chair. Staff GG said he/she went to get the vitals equipment and when he/she got back Staff BB was gone and the resident was alone in the room. The resident told him that she had been lowered to the floor and was not hurt. Staff GG said he received report at the beginning of the shift that the resident required assistance of one or two staff with pivoting but the resident had some increased weakness recently. Staff GG said he didn't know why the EA would have gone to			

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	the resident and tried to help since there were two other CNA's present. He didn't have any knowledge of any other resident transfers completed by Staff BB. On 8/2/21 at 12:30 PM Staff FF CNA said she worked on 7/31 when Resident #15 fell but assisted other residents at the time and did not know anything about the details of the fall. Staff FF said she worked in the hallway where Resident #15's room was and did not know why the EA would have needed to assist or if the resident's call light had been on at the time of the fall. On 8/2/21 at 1:58 PM, the ADON said that she received a phone call on Saturday night 7/31/21 that Resident #15 had been lowered to the floor and the nurse asked what kind of a note she should complete. The ADON said she told the RN to do a detailed progress notes and follow protocol. The ADON identified protocol for this type of incident as call the doctor and the family and complete a follow up skin assessment. The ADON said that she was not sure about time of day it was when she got the call and she talked to the DON later sometime on Saturday night. The surveyor asked if she usually get calls from nurses asking what to do in case of a fall, the ADON said sometimes they want guidance			

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Health Facilities Division
Citation

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Facility Name: **Accura Healthcare of Manning**		**Survey Dates:** **7/13-8/3/21**	
Facility Address/City/State/Zip **402 Main Street** **Manning IA 51455**			
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	especially when it's an agency nurse. The ADON said she asked Staff EE if it was a standard fall or just a lowering to the floor. The surveyor what the difference was in the documenting of a fall verses lowering to the floor and the ADON said that both would require a detailed progress note, incident report and notification of family and the doctor. The ADON said Staff EE RN worked at the facility for about 2-3 weeks and she would have expected that an RN would have an understanding of the follow up assessments to complete and the incident report risk management process. The ADON stated staff are taught upon hire to fill out an incident report for falls, unwitnessed falls, elopements, skin issues or unusual events. When asked if she could provide copy of this education, the ADON said that it is verbal education only so there was no documentation of the details of that education. She said that agency staff are provided the same education as permanent staff. The ADON said that she did not have any knowledge of the EA transferring any other residents. On 8/2/21 at 3:51 PM a family member for Resident #15 said the resident didn't reside at the facility very long but the family member thought			

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	everything was okay so far. The family member identified receiving a message from the DON that morning that staff lowered Resident #15 to the floor on Saturday evening. The family member looked at their phone and said the call came in at 12:03 PM. On 8/2/21 at 4:05 PM Staff BB EA stated she discussed the incident with the DON that morning around 11:30 AM. Staff BB said she entered the resident's room around 4:30 on 7/31/21 and offered to help the resident transfer from the recliner to the wheel chair. Staff BB said she moved the wheel chair close to the recliner and the resident stood up and started moving herself around to the wheel chair with her back to the night stand next to the chair. Staff BB grabbed the resident's upper arm, and while trying to get closer to the resident, the EA tripped over her own feet and fell off balance and leaned into the resident, causing the resident to lose her balance and fall. Staff BB said she then grabbed the residents back and lowered her down to the floor. The resident did not have a gait belt on. Staff BB was not sure if the call light activated prior to the incident. Staff BB sent a text to Staff E and asked for some help, that's when Staff GG came down the hallway to see what she needed. Staff BB said she stayed with the resident while Staff GG got the vitals' equipment. Staff BB said she			

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	received training on EA and had no training on resident care. On 8/3/21 at 10:38 AM Staff E stated was not in the room when Resident #15 fell because she helped with a different resident. Staff E said she did not have any interaction with the resident earlier in the shift and did not know if the resident activated her call light. Staff E said she got a text message from Staff BB to come help in the room of Resident #15. She said that she was busy so then went to Staff GG and asked him to go assist. Staff E maintained that she had not knowledge to Staff BB transferring other residents. 3. A Minimum Data Set (MDS) dated 6/4/21 assessed Resident #8 with a Brief Interview for Mental Status (BIMS) score of 5 (severe cognitive deficit). The MDS showed the resident required limited assistance one staff for transfers, toileting and walking. The MDS indicated the resident used a motion sensor and an elopement alarm to help monitor her activity. The care plan updated on 2/13/21 revealed Resident #8 had dementia and could transfer and ambulate independently with the use of a walker. The care plan identified the resident with self-care deficits and required staff to assist with activities of daily living.			

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	On 7/14/21 at 11:45 AM Staff C LPN revealed Resident #8 exited the building unattended around 6:00 PM at the beginning of Staff C's shift. Staff C said the resident got to the corner of the building. Staff C revealed door alarms sounded from hallway 2, but the elopement system did not engage the magnet to prevent the door from opening. The elopement system should activate an alarm and engage the door magnet to prevent a dementia patient from leaving the facility without staff knowledge. On 7/19/21 at 9:54 AM the surveyor asked the DON if Resident #8 left the building without staff knowledge in May. The ADON and Staff V RN were also present. The DON stated the resident went outside but it was not an elopement and there was no incident report completed because the door alarm sounded and Staff M, LPN walked the resident outside, just like residents are taken outside for activities. On 7/19/21 at 9:57 AM Staff M LPN said the door alarm activated and she saw Resident #8 open the door from down the hallway. She said that the door magnet did not engage as it should have so Resident #8 got the door open, she got out onto			

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	the patio. When asked if she documented the incident, Staff M said she didn't remember. When asked if this type of incident would normally require an incident report and documentation in the nursing note, she said that it should since the door magnet did not function properly. On 7/20/21 at 7:50 AM the surveyor asked Staff M found the date or documentation of the incident with Resident #8 and she said that she had not. A MDS dated 5/20/21 assessed Resident #7 with a BIMS score of 6 (severe cognitive deficit). The MDS revealed the resident required extensive staff assistance for toileting and was independent with walking and transferring. The MDS included diagnoses of: dementia, diabetes mellitus and unspecified hearing loss and identified the resident used an elopement alarm daily. An elopement risk assessment completed on 6/8/21, identified Resident #7 at high risk for elopement and used an elopement system bracelet to help monitor the resident's movements. A nursing note entered on 5/24/21 at 12:49 PM for Resident #7 revealed the elopement system bracelet checker not functioning due to need for			

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	new battery, battery replaced and device then functioned. On 7/14/21 at 5:40 LPN Staff Q revealed Resident #7 exited the building unattended on a Sunday night in June. The facility experienced trouble with the elopement monitoring system and the magnet that prevented the door from opening did not work. On 7/19/21 at 7:09 AM Staff G LPN reported the night that Resident #7 got out unattended, Staff G worked in the nursing station/dining area and the door alarm sounded. Staff G identified the DON as in the building at the time and the alarm panel indicated that the East door opened. Staff G went down the 400 hallway and did not see Resident #7. Staff G then went to the North side of the building and saw the DON with the resident as she brought the resident back inside. Staff G said the elopement device on Resident #7 did not engage the magnet on the door as designed. On 7/15/21 at 8:52 AM the maintenance manager (MM) showed the surveyor where the location of the magnets at the top of the door and how they engage when the elopement device got close. The MM said the magnets got rusty in the past so he sanded them off to make a connection. The MM said he's only sanded them one time and			

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	he's worked in the facility since October 2020. MM couldn't say exactly when he sanded them and he did not keep a log of when he fixes things. On 7/15/21 at 11:30 AM DON said that she called Feld Security about the door magnets and asked about the safety feature that when the door is pushed over and over again it opens. She said Feld Security stated that what may be happening is that when it's pushed over and over, the magnets become misaligned and that is why it may come open but this would be a malfunction, not a safety feature. On 7/13/21 at 8:40 AM the DON got an elopement monitoring bracelet device from her office. She first tested the bracelet to a meter that staff used to test on the residents while they wore the bracelets. The meter indicated that the bracelet was in working order. The DON then took the device to the door at the end of hallway one and as she got closer to the alarm on the wall the light did not change on the panel and the magnets did not engage. The DON said it wasn't working so she was going to go back to her office and get a different bracelet. At that point, Staff B CNA came out of a resident's room with Resident #4 who wore an elopement bracelet. The surveyor asked Staff B to walk the			

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	resident closer to the door. As she got close to the panel on the wall, a light changed to red, but since the latch on the door did not latch properly, the magnets did not engage and the door could be pushed open. The DON, ADON and Administrator were present and all said they did not know of the door not latching properly. On 7/15/21 at 7:05 AM the DON denied ever having any other elopement device bracelet give a false reading on the monitor. When asked if the staff still used this device to determine the function of the bracelets residents wore, she said yes it was still in use. On 7/15/21 at 10:14 AM DON said that they continued to use the same device on the residents' elopement bracelets and the staff were not moving the resident toward the door to verify that it is working. On 7/22/21 at 11:00 AM the surveyor asked the DON about staff documenting "DONE" when there was a discrepancy between what the tester saying it functioned and then going to the door and finding that it didn't work. She said the service said that can happen due to placement on the resident, like under a sock, vibration to system, weather related, dryer vibrations. The Don stated she felt confident with the system and			

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	stated nothing was 100% fool proof. She said that they do not have the nurses walk the residents to the door to double check function. 4. A review of charts revealed that the elopement monitoring bracelets continued to be used on three resident past the expiration dates. a. A MDS dated 5/13/21 assessed Resident #12 with a BIMS score of 4 (severe cognitive impairment). The resident required extensive assistance of one staff for transfers, walking, and toileting and locomotion. A care plan revised on 2/14/21 showed Resident #12 would wander throughout the facility by peddling in the wheelchair. Staff were directed to check for functioning and placement of elopement bracelet. A risk assessment elopement dated 5/10/21 at 11:47 PM identified the resident at high risk for elopement, According to the orders tab in the electronic chart, the bracelet was changed for Resident #12 on 7/13/21 at 11:00 PM. On 7/22/21 the DON provided a copy of a hand-written sheet dated 11/11/20 with a list of residents with bracelets and the expiration dates.			

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	The list included: Resident #12 with expiration date May of 2021 b. A MDS dated 5/13/21 assessed Resident #14 with a BIMS score of 3 (severe cognitive deficit). The resident required extensive assistance with the help of one for transferring, walking and toileting. A risk assessment for elopement dated 5/12/21 at 3:49 PM, identified Resident #14 at risk and able to self-propel in the wheel chair and exhibited exit seeking behavior. The care plan for Resident #14 revealed the resident wandered through the facility by peddling in the wheelchair. The care plan directed staff to find structured activities for the resident. On 7/22/21 the DON provided a copy of a hand-written sheet dated 11/11/20 with a list of residents with bracelets and the expiration dates. The list included: Resident #14 with expiration date of May of 2021 c. Resident #8's MDS dated 6/4/21 assessed the resident with a BIMS score of 5 (severe cognitive deficit). The resident required limited assistance with the help of one staff for transfers, walking, toileting and bed mobility.			

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	A risk assessment for elopement dated 6/28/21 at 3:24 PM, revealed the resident not at risk for elopement with a score of 0. The assessment indicated the resident was not independently mobile with or without assistive device. A quarterly nursing assessment dated 6/3/21 at 3:25 PM indicated the resident transferred with limited assistance and could ambulate in her room with the use of a walker and full weight bearing status. A nursing note dated 7/14/21 at 7:54 AM stated the elopement device for Resident #8 expired and staff placed a new device on the left wrist. On 7/22/21 the DON provided a copy of a hand-written sheet dated 11/11/20 with a list of residents with bracelets and the expiration dates. The list included: Resident #8 with expiration date of June of 2021. On 7/20/21 at 9:17 AM the surveyor asked the DON if she could get the surveyor a list of elopement bracelet devices changed and the expiration dates of the removed bracelets. The DON said they did not change out any elopement bracelets the past week, they just changed the location of the bracelet on residents because after talking to the security company they said a			

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	change in location may help with the device detection. The surveyor asked her if she talked to the security company about the tester giving a false reading the previous week. She said she did not talk to him about that concern. On 7/21/21 at 1:17 PM in an interview with the DON and LPN Staff V present, the surveyor directed the DON to a nursing note that indicated that the elopement bracelet for Resident #7 expired so it was being changed. The surveyor reminded her that a list of expired bracelets had been requested and she indicated that the bracelets had not expired but locations changed. She then said that some actually expired but she did not know where the list of expired bracelets was at that time. 5. When the surveyor entered the facility on 7/13/21 at 7:45 AM Staff X from housekeeping was vacuuming in the front sitting area. Staff X opened the door for this worker and went to get a nurse to do the screening. Staff M LPN completed the screening and then this worker asked her to push open the door with an alarm on it. She identified the alarm panel in the nurses station/dining area, and acknowledged an alarm could not be heard when the door opened. The surveyor went with Staff M to the alarm panel in the dining room area and she flipped a switch that			

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	had been turned off. Staff X said they would do this sometimes when the housekeeper is vacuuming in the front entrance, but she could not say how long it may have been turned off. On 7/13/21 at 8:10 AM Staff X said that she did not turn the alarm off herself. On 7/13/21 at 2:57 Staff M went with this worker to check a door alarm and asked if it was ever difficult to hear the alarm when staff are in rooms with residents. Staff M acknowledged that it is difficult to hear the alarm panel from inside the residents rooms at the end of hallways. On 7/13/21 at 3:00 PM Staff B Certified Nursing Assistant (CNA) said that she cannot hear the panel door alarm when she is in a room at the end of the hallway with a resident. On 7/14/21 at 6:15 AM the panel of door alarm switches had a locked case installed. On 7/13/21 at 8:31 AM Staff D, ADON said that it had been installed and just the charge nurse had a key and can turn the alarms off. If someone is coming in and out and they want to temporarily turn it off, there was a black button to hold down during that time.			

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	On 7/26/21 at 8:50 Staff V, LPN went with the surveyor to two resident rooms at the end of hallway 3 and closed the doors and had Staff M set off the door alarms. The alarms could be very faintly heard. From room #48, with the television on the alarm could be very faintly heard. From room #17 with the air conditioner fan running and door closed, the alarm could not be heard. 6. On 7/13/21 at 8:40 AM the surveyor went to the exit door at the end of hallway one with the Administrator, DON and ADON. At that time, observation showed the latch on the fire door was stuck open and that the latch did not latch properly. On 7/14/21 at 1:25 PM Staff S Registered Nurse (RN) said that the door at the end of hallway one had not been latching properly for over 6 months and she told the DON it did not latch and that the elopement bracelets did not work properly. On 7/14/21 at 3:03 PM Staff J, LPN said she told the DON, ADON and a representative from the corporate office 5 months previously that the door did not latch correctly. On 7/15/21 at 8:52 MM said that he sprayed the latch with WD-40 and it was working. Staff V RN present for this conversation			

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	7. On 7/20/21 at 10:20 PM this worker was able to enter from the front door of the facility and push the green button to enter without the alarm sounding. Upon entrance, Staff Y CNA, Staff Z CNA and Staff AA CNA sat in the dining room at a table chatting. There were no residents in the dining room at the time. The surveyor asked for someone to complete screening and they said that the nurse on duty was doing rounds. The surveyor then went to the two medication carts in the dining room and found them both unlocked. Staff Q LPN then came up the hallway and continued rounds. At 10:30 PM the surveyor alerted the LPN to the fact that the medication carts were not locked. He said that they had just done the medication check with the offgoing nurse so he hadn't gotten back to lock it again. 8. A MDS dated 6/9/21 assessed Resident #11 with a BIMS score of 1 (severe cognitive deficit)s. The MDS showed that the resident required limited assistance with the help of one staff for bed mobility, transferring, walking, locomotion and extensive assistance with the help of one for toileting. On 7/20/21 at 11:23 PM Resident #11 was in the bathroom on the toilet. Staff Q asked why he			

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	didn't wait for help and the resident responded that he couldn't wait. There was a trail of urine on the floor from his bed to toilet. Staff Q then alerted the three CNA's in the dining room area to assist the resident. Staff Q said that Resident #11 had a bed alarm when he was first admitted but for some reason it had been discontinued. An admission assessment dated 7/3/21 at 2:59 PM contained a care plan focus area of risk for falls addendum. The focus area revealed the resident became fatigued easily and would attempt to transfer without assistance. The assessment indicated the intervention of a pull tab alarm would be added to the care plan to alert staff that he was trying to get up without assistance. Staff were directed to ensure the alarm was on and functioning. On 7/21/21 at 6:30 AM LPN Staff H said that Resident #11 no longer used an alarm because he hadn't been trying to transfer without help. On 7/21/21 at 1:17 PM the DON said that the expectation is that the medication cart is kept locked if the nurse is not within eyesight of the cart. She said that she was not aware the Resident #11 had been getting up on his own and would look into getting the bed alarm reestablished.			

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	FACILITY RESPONSE:			

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