STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165437	A. BUILDING _____ B. WING _____	C 11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CREST MANOR	100 BOLGER DRIVE FAYETTE, IA 52142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiency relates to the investigation of incident #72227 and was corrected October 30, 2017 prior to surveyor entrance. (See code of federal regulations (42CFR) Part 483, Subpart B-C)	F 000		
F 323 SS=J	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and	F 323	Past noncompliance: no plan of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/01/2017

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F 323	Continued From page 1 interviews with staff, the facility failed to provide adequate supervision to protect 1 of 4 residents from hazards. On 10/28/17, Resident #1 wandered away from the facility without staff knowing her whereabouts and sustained a facial laceration and contusion of the face. The resident had been seen by a witness walking on the access road to the nursing home which runs parallel to the nearby highway (approximately 40 steps) with a speed limit of 45 miles per hour. Staff interviews revealed the resident had two prior attempts early on 10/28/17 to exit the facility. Staff interviews revealed no staff were aware of Resident #1 whereabouts until alerted by the hospital emergency room. The facility reported Resident #1 may have left unnoticed when visitors exited and entered the front door code and turned off the alarm. The findings constitute an immediate jeopardy situation to resident health and safety. The facility identified a census of 51 residents. Findings include: According to clinical record review, Resident #1 entered the facility on 09-27-2017 and had diagnoses which included dementia, depression, high blood pressure and anxiety. The facility Minimum Data Set (MDS) assessment dated 10-04-2017 indicated Resident #1 scored 3 points (of 15) on the Brief Interview for Mental Status (BIMS) indicating severe cognitive decline. The assessment also indicated Resident #1 required limited staff assistance with bed mobility, transferring, ambulating in the room and corridor, toilet use and personal hygiene. Resident #1 required extensive staff assistance with dressing and bathing and was able to eat independently.	F 323	correction required.	

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F 323	Continued From page 2 Facility staff completed an "Elopement Risk Assessment" dated 10-05-2017. The assessment identified Resident #1 as being ambulatory, alert and oriented to person but not capable of making decisions. The assessment also indicated Resident #1 exhibited 4 of the possible 11 behaviors including: 1. new admission 2. currently takes medication which may cause confusion 3. exhibits routine or sporadic confusion, anxiety or disorientation 4. anger or resistance related to placement (e.g. wanting to go home, or to work, or somewhere else). Resident #1 was identified (with a check mark) to be "at risk" for elopement and to proceed with care plan. An additional comment was added dated 10-05-2017 indicating "no wandering behaviors noted at this time". [Resident #1 did not use a Wanderguard or similar alarm.] Resident #1's care plan (printed 10-13-2017) was reviewed. The plan identified the resident had cognitive impairments and short term memory. The care plan did not address an intervention for wandering, elopements or increase supervision. Documentation in the nurse's notes dated 10-28-2017 at 1303 (1:03 p.m.) indicated Resident #1 was very upset that morning wanting to exit and walk home. Staff redirected Resident #1 multiple times. The notation also indicated Resident #1 was combative with staff and refused to use the walker or let staff walk with him/her. After taking medication it was noted Resident #1 calmed down.	F 323		

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Documentation in the nurse's note dated 10-28-2017 at 1444 (2:44 p.m.) indicated Resident #1 went outside with staff following and then walking with Resident #1. The notation indicated Resident #1 would not allow staff to touch him/her. The notation also indicated that Resident #1 exited the building two times during the time frame of 2:00 to 2:44 p.m.

Documentation in the nurse's notes dated 10-28-2017 at 1600 (4:00 p.m.) indicated the facility received a call from the ambulance crew questioning about Resident #1. The ambulance crew indicated they had picked up Resident #1 south of the facility. The resident had fallen and an unidentified driver driving by on Highway 150 had seen her and called 911.

The emergency room report dated 10-28-2017 at 1615 (4:15 p.m.) indicated Resident #1 sustained a facial laceration, contusion of the face and abrasions of multiple sites. The resident report revealed the resident had most likely sustained the injuries while walking and landed on concrete with the point of impact as her head. The resident had been walking near the access road near the nursing home and a witnessed driving by observed her fall forward onto the cement and stopped to assist. Upon discharge, the resident's right eye was swollen shut.

Observation during the investigation identified : Resident #1 was found in front of the yellow house located at a dead end road that also runs in front of the facility and adjoins the facility parking lot. At the end of the dead end is a small wooded area. The road also runs parallel to a busy highway, Highway 150, which is a bypass to the city proper of Fayette and proceeds to the

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F 323	Continued From page 4 town of West Union. The road on which Resident #1 was found runs parallel to Highway 150 and is approximately 40 steps (less than 80 feet) between the two highways. The speed limit at the spot parallel to where Resident #1 was found was 45 miles per hour. For vehicles traveling south on Highway 150, the speed limit increases at that point from 35 miles per hour, which would indicate vehicles are increasing their speed at that point. The climatologist reported the weather on 10/28/17 at 3:30 p.m., had been 36 degree, cloudy with wind North at 12-18 miles per hour, 27 degree wind chill. The facility investigation dated 10/28/17 revealed the code for the door alarm had been written on a piece of paper and placed by the door. During an interview on 11-13-2017 at 2:12 p.m. Staff A indicated Resident #1 had been upset the morning or 10-28-2017. Staff A explained that Resident #1 had been awake by 6:30 a.m. and was at the door, setting off the [door] alarm. At approximately 7:15 a.m. Resident # 1 wanted to go outside. At that time Staff A stated Resident #1 did take her medication. Staff A stated about 9:00 a.m. a family member visited Resident #1 and Resident #1 cried and wanted to go home. The family member expressed concern to Staff A, so she administered a PRN (as needed) medication and sat with Resident #1. Resident #1 continued to express the desire to go home, but Staff A noted Resident #1 to be calmer after lunch and participated in looking at pictures and folding laundry. Staff A stated when she left the facility at 2:00 p.m. Resident #1 was seated in the lounge waiting for a music activity to begin.	F 323		

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F 323	Continued From page 5 During an interview on 11-13-2017 at 3:09 p.m. Staff B stated she arrived at work about 2:00 p.m. on 10-28-2017 and heard the front door alarm sound. Staff B stated a resident from the assisted living unit was shutting the door alarm off and when Staff B responded to the alarm she immediately observed Resident #1 outside the building just a few feet from the front door. Staff B stated she went to Resident #1 and explained that it was cold outside and Resident #1 agreed to return into the facility. Staff B stated she assisted Resident #1 to sit in a recliner in the lounge. Staff B also stated she alerted the nurse on the 200 hall, and was told to "just keep an eye on him/her". During an interview on 11-14-2017 at 10:59 a.m. Staff C stated he was assisting residents to the living room when the door alarm sounded. He stated Staff B responded and that Staff B came back into the facility with Resident #1. Staff C stated Staff B assisted Resident #1 to sit in the recliner. Staff C stated about 15 to 20 minutes after the music had started he heard the door alarm again and observed Resident #1 leave the building. Staff C stated he ran after Resident #1 and tried to talk to her trying to convince Resident #1 that it was cold outside and she should go back inside where it was warm. Staff C stated Resident #1 kept arguing that she had been inside all day and wanted to go outside for awhile. Staff C stated it was several minutes before Resident #1 was finally convinced that it was cold out and to return in the building. Once inside, Staff C stated Resident #1 sat at a dining room table, seemingly enjoying the music and accepted a cup of coffee and a cookie. Staff C stated the music ended at 3:00 p.m. and	F 323		

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he then began assisting residents out of the dining room. Staff C stated he last observed Resident #1 about 3:05 p.m. seated at a dining room table with another resident and their family. Staff C stated he did note about 3:30 p.m. that Resident #1 wasn't' in her usual chair, but thought one of the nursing assistants had probably assisted Resident #1 to use the restroom.

During an interview on 11-14-2017 at 10:33 a.m. Staff D stated she was alerted at report that Resident #1 had been irritated/restless during the day and had attempted to exit the front door, or at least headed in that direction.
Staff D stated about 2:15/2:20 p.m. the door alarm sounded and as she responded, she noted Staff B returning into the building accompanied by Resident #1. Staff D stated the alarm sounded again about 2:35/2:40 p.m. and when she responded she observed Staff C outside with Resident #1. Staff D stated it didn't look like it was going well, so she went outside and touched Resident #1 to guide her to turn around and Resident #1 stated, "Get your hand off me." Staff D stated she and Staff C walked with Resident #1 to the assisted living door, and then Staff D said to Resident #1, "Do you realize we are going north; do you know north is the coldest place; we should go south. At this point Staff C and Staff D were able to assist Resident #1 in turning around and head back towards the facility. Resident #1 was able to read the sign, "Maple Crest Manor" and commented on who would want to live there, but then agreed to return inside the building after being told it was warm inside.
Staff D stated Resident #1 joined other residents in listening to the music activity and noted Resident #1 was tapping his/her hand in time to the music. Staff D stated she then went to the

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nurse's station to chart what had just occurred. Staff D stated the music concluded at approximately 3:00 p.m. and she assisted residents in returning to their rooms. She also had a medication pass to begin. Staff D stated she did not notice that Resident #1 was missing until she received a phone call from ambulance personal.
Staff D stated she did not hear another alarm sound, and can only assume that Resident #1 followed someone out of the building. Staff D also indicated nothing additional was implemented, other than to "keep an eye on her" to ensure Resident #1 did not exit the building. Staff D stated Resident #1 seemed to enjoy the music and Staff D thought the alarm would sound if Resident #1 attempted to leave again.

A test of the front door alarm was conducted on 11-13-2017 at 11:24 a.m. The Director of Nursing entered the code on the alarm pad (to silence the alarm) and then activated the automatic door opener. The door remained opened for approximately 20 seconds at a 90 degree opening, (the surveyor counting 1001, 1002, 1003....). After approximately 20 seconds the door closed, with the alarm not sounding at any time. The Director of Nursing stated at one time the alarm did sound before the door closed, but she checked with the facility Administrator who thought maintenance had made an adjustment so the alarm did not sound before the door closed.

During an interview on 11-14-2017 at 9:37 a.m. the Administrator indicated it was her understanding that (on an unknown date) "State" had directed that all residents were to be considered an elopement risk.
In addition it was her understanding that all doors

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F 323	Continued From page 8 needed to be alarmed at all times. As a result, the facility discontinued the wanderguard system since all doors were alarmed. The facility Administrator stated that family members, frequent visitors and other individual such as sales representatives were given the code to silence/bypass the door alarm. The Administrator also expressed some concern that on weekends, there are less staff in the front office to observe if residents are near the front door, or attempting to exit. On 10/28/17 the facility implemented 15 minute checks for Resident #1. The front door code that was placed at the front door (for visitors) was removed. Resident #1's care plan was updated to address elopement intervention(s). On 10/30/17, the facility abated the IJ when they completed the following: Added a sign to the front door that indicated to not let residents follow them out the door. Staff were educated that before they reset the door alarm, to ensure a resident had not gone outside. The facility changed the code for the front door. The facility re-assessed all residents for elopement risk and Wanderguard bracelets were placed on resident at risk including Resident #1. The facility placed a new system which will lock if a resident has a Wanderguard bracelet on them and they are in close promityity which will be alarmed 24/7 hours with a special code to bypass the lock which will only be known by selected employees (charge nurses, etc.).	F 323		