STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	C 06/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH HEIGHTS	601 S PRAIRIE STREET MOUNT PLEASANT, IA 52641

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F 000	INITIAL COMMENTS Correction Date 06/21/18 The following deficiencies relate to the investigation of facility reported incident 76368-I and complaints 76380-C and 73678-C conducted 6/20/18-6/21/18. Facility reported incident 76368-I was substantiated. Complaints 76380-C and 73678-C were not substantiated.	F 000	Please see attached	6/21/18
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide adequate nursing supervision to prevent accidents for 1 of 2 residents in the facility with a history of wandering (Resident #1). On 6/3/18, Resident #1 exited the building without staff knowledge creating a risk for serious injury or death. The findings constitute an Immediate Jeopardy (IJ) to the resident's health and safety. The facility reported a census of 46 residents. Findings: 1. According to the MDS (Minimum Data Set)	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Penny Mullins	Administrator	07/19/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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assessment tool dated 4/15/18, Resident #1 had diagnoses that included non-Alzheimer's dementia. The MDS documented the resident required supervision of 1 staff for transfers, walking, and eating, limited assistance of 1 staff for bed mobility, dressing, and personal hygiene, and extensive assistance of 1 staff for toilet use and bathing. The MDS listed the resident's cognition as severely impaired and documented the resident exhibited fluctuating periods of inattention.

Review on 6/20/18 at 12:50 p.m. of the facility's video surveillance of 6/3/18 revealed the following:

*At 6:36 p.m., an interior camera showed the resident walked toward the North Door.
*At 6:39 p.m., an exterior camera showed the resident walked out of the facility to the middle of the north parking lot located on the side of the building.
*At 6:41 p.m., an exterior camera showed the resident walked to the north side of the east parking lot located in front of the building.
*At 6:43 p.m., an exterior camera showed the resident walked to the south side of the east parking lot located in front of the building. The resident touched the door handle of a vehicle briefly.
*At 6:44 p.m., an exterior camera showed the resident walked toward the front door, but then briefly headed south (away from the direction of the door) before heading back toward the building. The vehicle of a visitor pulled into the parking lot.
*At 6:46 p.m., an exterior camera showed the resident close to the front door alongside visitors.
*At 6:47 p.m., an interior camera showed the

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resident inside in the dining room.

During an observation on 6/20/18 at 1:00 p.m., the surveyor requested the Administrator open the north door while the surveyor went into Room 313 (midway down the hallway) and close the door. When the alarm sounded, the surveyor could hear it only faintly. Room 313 was quiet and empty with no television sounding.

An observation of the front door (where the resident re-entered the building on the evening of the elopement) revealed the door required an enter code in order to open.

A Wandering Assessment, dated 4/13/18, displayed a "yes" answer for the following 5 questions:

1. "Has the resident wandered? Did the resident wander at home, in previous living setting; family/significant others voiced concerns?"
2. "Does the wandering place the resident at significant risk of getting to a potentially dangerous place (stairs, outside the facility)?"
3. "Is the resident cognitively impaired with poor decision making?
(poor decisions, cueing needed, intermittent confusion, inattention, disorganized thinking)?"
4. "Does the resident have visual, auditory, or communication deficits?"
5. "Does the resident have a diagnosis of dementia, Alzheimer's, anxiety, depression, schizophrenia, OBS (Organic Brain Syndrome-a form of decreased mental function due to a medical or physical disease, rather than a psychiatric illness? This differs from dementia), delusions, or hallucinations?"

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The assessment directed more than 3 "yes" answers indicated a "definite risk for elopement". A nursing note entry, dated 5/24/18 at 10:02 a.m., documented the resident wandered into another resident's room and staff directed her to her own room.

A nursing note entry, dated 5/24/18 at 10:19 a.m., documented the resident visited 4 other resident's rooms and wandered in the hallway. Staff redirected the resident back to her own room.

The Interim Care Plan, dated 9/15/16, documented the resident "may wander outside-did at home".

Review of the current care plan revealed the following:

*10/9/17 entries stated the resident had severe cognitive impairments and confusion and directed staff to direct the resident to the correct room as needed.
*A 6/10/18 entry stated the resident liked to wander and directed staff to check on the her hourly to ensure safety.
*A 2/23/18 entry stated the resident walked throughout the facility with a walker with supervision of staff.

An undated document, provided by the Administrator on 6/21/18, listed 2 residents in the facility who wandered.

The undated facility policy "Door Alarm: Potential Resident Elopement" directed staff when a door alarm sounded or pager alerted, the staff closest to the alarming door were to radio to the charge nurse to indicate they would check the door. The

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policy indicated the charge nurse was responsible for ensuring staff checked into the reason for door alarms.

During an interview on 6/20/18 at 10:49 a.m., Staff E, Housekeeper, stated she observed two visitors bring the resident back into the facility the night of the elopement. She stated she had a hearing impairment so could "not really" hear the door alarms.

During an interview on 6/20/18 at 12:00 p.m., the Administrator stated she was out of state at the time of the incident but said her understanding was that no staff observed the resident leave although video showed the resident outside for a total of 9 minutes. She reported a visitor let the resident inside. The Administrator also reported the resident left via the north door and the door alarm sounded for 40 minutes before staff deactivated it; staff were busy at the time.

During an interview on 6/20/18 at 12:50 p.m. prior to viewing the facility video, the Administrator stated the time stamp of the hour was 1 hour off but the minutes were correct.

During an interview on 6/20/18 at 12:55 p.m., the Administrator stated at the time of the elopement the pagers of the 3 CNAs (Certified Nursing Assistants) and the nurse alerted when the north door opened.

During an interview on 6/20/18 at 1:33 p.m., Staff A RN (Registered Nurse) stated when a door opened, the doors alarmed but she could not hear the alarm in a resident room with the door closed. She stated the staff pagers also alarmed when doors opened and then alarmed again in 5

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minute intervals and a message would show up on the pager. She stated in the old building the resident would "occasionally" try to get out the front door, but wore a wanderguard. She reported in the new building, the resident did not wear a wanderguard and she had never seen her try to leave the building.

During an interview on 6/20/18 at 1:41 p.m., the Office Manager stated in the old building, the resident wore a wanderguard and would approach the door but did not attempt to leave. She stated she did not know the resident's intentions when she went up to the door. She stated in the new building she did not see the resident try to exit.

During an interview on 6/20/18 at 1:46 p.m., the DON (Director of Nursing) stated in the old building, the resident wore a wanderguard and would get close enough to the doors to activate the wanderguard alarm. She reported she had never seen the resident display exit-seeking behavior in the new building. The DON stated after the incident, the messages on the pagers were changed to make them easier for staff to understand. She said the way the pager system worked was the pager sounded initially and then sounded in 5 minute intervals until the door was reset.

During an interview on 6/20/18 at 2:50 p.m., Staff B, CNA reported she worked for a Staffing Agency the facility utilized and the night of the resident's elopement was her first night in the new building. She had worked in the facility's old building. She thought she heard the alarm of the door the resident exited, but it was very soft. She reported she was not familiar with the pager

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system or the door alarms and received no training or education regarding this prior to her shift. She stated at one point in the evening she saw Staff C checking doors, and later found out a visitor had found a resident.

During an interview on 6/20/18 at 3:19 p.m., the DON stated prior to the incident she did not personally educate new agency staff regarding door alarms and pager alarms. The CNAs did this, but did not have a guideline for what they should go over for orientation. She stated since the elopement, she trained each staff member and has them sign an orientation checklist.

During an interview on 6/21/18 at 11:14 a.m., Staff D LPN (Licensed Practical Nurse), an agency staff member, stated she was a nurse but worked in the capacity of a CNA the night of the incident. She stated at the time of the incident, she was on break and didn't check her pager during that time, but the situation was under control when she returned to the floor. She stated the night of the elopement was her first night working in the facility and she went into her shift "knowing nothing". She reported she had no idea how to work the pagers, so on her second night working she inquired about this.

The facility abated the Immediate Jeopardy situation on 6/12/18 by implementing the following:

1. The facility changed the wording and phrasing the pagers displayed to make the alerts easier for staff to comprehend and act upon.

2. The facility clarified the Charge Nurse's role in coordinating which staff will respond to the door

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F 689	Continued From page 7 alarm and calling an "all clear" when staff identified and resolved the source of the alarm. 3. The facility developed an orientation checklist for Staffing Agency staff that included the pager system and alarms. 4. The facility educated the staff regarding the new policies and procedures, pagers, and Staffing Agency staff orientation.	F 689	Please see attached sheet	
F 843 SS=B	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii).	F 843	06/21/18	

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§483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to have a current transfer agreement with the hospital. The facility reported a census of 30 residents.

Findings:

1. A transfer agreement with the local hospital listed a contract date of 9/1/95. The facility lacked documentation of a current transfer agreement.

During an interview on 6/21/18 at 11:00 a.m., the Administrator stated she could not locate a more recent transfer agreement but called the hospital to obtain one.

Savannah Heights

Self Report Survey

June 20-21, 2018

Please accept this plan of correction as my credible allegation of compliance.

The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission or an agreement by the facility for the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction for the deficiencies was executed solely because it is required by provision of state and federal law.

F 843 The facility must have a current transfer agreement with the hospital. We have updated our transfer agreement in accordance with section 1861 (l) of the Act. The Administrator or Designee will review periodically. QA will monitor this on a yearly basis. Correction date: 07-21-2018.