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GOOD SAMARITAN SOCIETY - ALGONA	412 WEST KENNEDY STREET ALGONA, IA 50511

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F 000	INITIAL COMMENTS Correction date 4.13.20. The following deficiencies relate to the investigation of Incident #89983-I completed March 19-31, 2020. Incident #89983-I was substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B -C).	F 000	"Preparation and execution of this response and plan of correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusion set forth in statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations Manual. All issues for F689 were resolved by 3/20/2020 All issues with F712 were resolved by 4/13/2020	
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, facility policy and staff interviews the facility failed to ensure each resident received adequate supervision to prevent elopement for 1 of 3 residents reviewed (Resident #1). Resident #1 exited the facility unsupervised which resulted in an immediate jeopardy to residents health and safety. The facility reported a census of 73 residents. Findings include: The Nursing Admit/Re-Admit Data Collection tool dated 3/11/2020 at 11:47 a.m., documented Resident #1 was admitted for skilled care on 3/11/2020. Under the Behavior/Cognitive section (*) items indicate risk for elopement: Resident was checked for none of the above. Resident	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/15/2020

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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F 689	Continued From page 1 was not marked as may be at risk for elopement. Under the Prognosis heading, it was checked no, to answer if the resident had a condition or chronic disease that may result in a life expectancy of less than 6 months.The Level of Consciousness and Orientation documented this resident was alert and oriented to person. Under the Walk section it was documented Resident #1 could shift weight from one leg to the other, taking one step forward and one step back. The documentation revealed assistive devices and employee assistance of gait belt, guided maneuvering of limbs, and a front-wheeled walker were needed for Resident #1 to take the steps forward and back. This document indicated Resident #1's care planning for ambulation would include staff assist and a mobility device. A Care Plan with a focus area, initiated on 3/11/2020, identified a self care performance deficit related to dementia and recent fall with subdural hematoma evidenced by confusion and a recent surgery. Interventions directed staff to use one to two staff to assist Resident #1 with ambulation with a front wheeled walker and gait belt and directed one staff to assist with between surface transfers using a gait belt and a FWW (front wheeled walker). A focus area initiated on 3/12/2020, identified the resident had impaired thought processes related to dementia and a recent fall with subdural hemorrhage without loss of consciousness as evidenced by confusion, needing time to respond to questions, and the resident dozing off easily. The goal was the resident would remain oriented to self, family and surroundings. Interventions included: staff to use consistent, simple, direct sentences; to present just one thought, idea or command at a time; to break tasks into one step at a time; and alerted	F 689	F689 Resident #1 was immediately brought in to the facility when discovered, assessed, and was seen in the emergency room. Temporary door sensors were put at the upper level door exits on 3/20/2020 in the interim of new door alarms arriving. All staff educated on the elopement policy by DNS and administrator from 3/17/2020-3/20/2020. Quiz completed at the end of the education. New door alarm system put into place 3/25/2020. We have elopement drills for each shift on a monthly basis X3 months and each month rotating shifts thereafter. Resident #1 has since returned to the facility. Upon return the following interventions were implemented; wander guard on wrist, movable motion sensor, and low bed in resident room. This has the potential to affect All residents who have an elopement risk.	

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F 689	Continued From page 2 staff that resident used to walk every day. A focus area initiated on 3/12/2020, identified an alteration in activity involvement evidenced by adjusting to the facility and involvement with therapy. An intervention directed staff to monitor resident for significant changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function. An Order Summary Report with active orders dated 3/16/20, documented diagnoses for Resident #1 included atrial fibrillation, dementia, and traumatic subdural hemorrhage without loss of consciousness. A Progress Note dated 3/16//20 at 2:18 p.m., documented resident was sitting in the solarium in her wheelchair leaning to the right and staff were able to catch her. The resident did not hit her head. It further documented Resident #1 was trying to stand up and get off the floor. The resident "was raised to (her) feet and was able to stand and bear weight without difficulty". A Progress Note dated 3/16/20 at 5:25 p.m., noted Resident #1 was up with assist of 2 staff, was able to bear weight, stand and pivot transfer. Some confusion was noted but resident's mood was pleasant and resident was cooperative with staff, A Progress Note dated 3/17/20 at 1:26 a.m., documented a change in condition including abnormal vital signs, altered mental status, fall, uncontrolled hypertension, cold to touch, low body temperature. A Progress Note dated 3/17/20 at 1:30 a.m., documented by Staff B, Registered Nurse (RN),	F 689	Random audits of staff knowledge and elopement drills will be conducted. Audits for door alarm checks will be completed by the maintenance supervisor. Audits will be assigned by QAPI and conducted bi-weekly x1, then monthly x1 by designated staff. Findings will be brought to QAPI committee. QAPI committee will review findings and determine to continue or discontinue audit.	

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noted Staff B was doing hall checks and vital signs when Staff B noticed this resident's bed was empty. The wedge pillow was still in place, pad and gripper socks were in the bed. The RN alerted the Certified Nursing Aides's (CNA) to start a hall check immediately. The RN exited the hallway door and realized there was no light to see and then went back to the nurse's station to obtain a flashlight. The RN then exited the 100 doorway and found Resident #1 around the corner of the building, on the sidewalk, lying on her left side. The resident had multiple skin tears and abrasions on her legs, feet and arms. The resident had a pulse. The RN directed the CNA that had gone outside with the RN to get a wheelchair. Another aide exited the building to assist. Two staff assisted the resident into the wheelchair and brought her into the building, then transferred the resident to bed. The resident was found to be hypertensive and the temperature would not register on a tympanic (ear) thermometer. Covered the resident in multiple warm blankets and wrapped the resident up. Call placed to the physician and orders received to transfer to the hospital per ambulance. A CNA stayed with the resident while calls were placed. Staff B continued to obtain vitals while awaiting the ambulance. The resident's temperature did rise to 91.8 and blood pressure normalized while covered. The resident's pupils were equal, round and reactive to light. Responding only to painful stimuli. She did start to open eyes when in bed. Notified Director of Nursing of incident.

A Progress Note dated 3/17/20 at 2:15 a.m., stated ambulance arrived and IPOST and medication sheets were sent with.

A Progress Note dated 3/17/20 at 2:40 a.m.,

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documented communication with resident's family notifying of the incident and transfer to hospital per ambulance.

A Progress Note dated 3/17/20 at 2:53 a.m., documented intervention for incident is to do elopement drills and training for staff and place wanderguard on resident upon return to facility.

The Incident Report #1370 dated 3/17/20 at 1:31a.m., with a revision date of 3/17/20 at 4:49 p.m., documented Incident Location as outside the building (on premises). The documentation included information from the Progress Note dated 3/17/20 at 1:30 a.m.. The documentation included notification to the resident's daughter, Administrator, and falls committee. The intervention documented was to provide elopement drills and training and place wanderguard when the resident returns to the facility. The resident was transported to the hospital per ambulance. Injuries were documented as abrasion and skin tear. This report documented the level of pain as 0. Breathing was normal (0), negative vocalization was none(0), facial expression was smiling or inexpressive(0), body language was relaxed(0), and consolability was no need to console(0). Documentation of level of consciousness was documented as stuporus (responsive only to vigorous stimulation) and mobility was documented as ambulatory with assistance. Mental Status documented resident was not oriented to person, situation, place or time nor was resident disoriented as none of these options were checked. Predisposing Environmental Factors were checked as equipment/assistive devices, flooring type, floors uneven, and poor lighting. Predisposing Physiological Factors were

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checked as confused, impaired memory, gait imbalance, and impaired vision. Predisposing Situation Factors were checked as alarm did not sound, improper footwear, alarm sounded. Other information documented door alarm sounded, but main alarm buzzer at desk did not sound. The report documented no witnesses found.

The hospital Emergency Documentation Report dated 3/17/2020 at 5:08 a.m., showed the chief complaint as the patient from a nursing home wandered outside and fell. Was laying outside for approximately 1 hour. Under The History of Present Illness heading it was documented that the caucasion female with recent subdural and some arachnoid hemorrhages requiring craniotomy presented to the Emergency Department (ED) via Emergency Medical Services (EMS). The patient was found outside of her nursing home and it was suspected she was outside for approximately 1 hour. It was unknown if the patient fell or not. EMS reports she was extremely cold on arrival with an initial temperature of 72 degrees Fahrenheit. An IV was inserted and warm fluids were started in the ambulance as well as warm blankets. Upon arrival to ED the patient's temperature had risen to 95.5 degrees Fahrenheit.
The report went on to document the patient would open eyes initially but otherwise was fairly somnolent and nonreactive. Patient became more interactive throughout her stay but had some difficulties with word finding and expression. The Assessment/Plan documentation revealed 1)subdural hemorrhage and 2) hypothermia. It documented an increase in subdural hemorrhage with a mass-effect and midline shift. It documented options were discussed with patient and her family, which

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included transfer to another hospital for neurosurgery consult and possible surgery, or staying in hospital or back to nursing home with hospice care. It was documented the discussion included if patient stayed at hospital it would likely be fatal. The report documented the hypothermia improved throughout the patient's stay with warm blankets and warm IV fluids.

A Progress Note dated 3/17/20 at 5:19 a.m., documented a call was received from an employee at the hospital. Stated the resident has another brain bleed and family has decided they would like her to go on hospice. Wondering about facilities current hospice protocols. Notified of current protocols in place and stated the family will likely keep the resident at the hospital for hospice care but will let us know for sure.

A Nursing Admit-Readmit Data Collection tool dated 3/21/2020 at 9:37 a.m., documented the reason resident was hospitalized was fall with minor brain bleed. Under the Behavior/Cognitive heading (*) Items indicate risk for elopement, short-term memory loss and resident may be at risk for elopement were checked. Care planning for behavior/elopement documented the resident had potential for elopement with a goal of the resident will not leave the facility unattended. Under Prognosis heading, it was checked yes, the resident had a condition or chronic disease that may result in a life expectancy of less than 6 months. Under the Comments heading, it documented the resident was admitted with Hospice. Under the Restraints heading, it documented the use of a motion sensor. The reasons for device was documented as attempts self-transfer, climbs out of bed, forgets ambulation device (e.g. walker, cane), frequent

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F 689	Continued From page 7 falls, slides out of chair/wheelchair, and unsteady gait. In an interview on 3/24/20 at 5:35 p.m., the Nursing Home Administrator (NHA), stated the resident returned to the facility on Saturday 3/21/20. The NHA reported the resident fell at home which resulted in a brain bleed. The resident went to the Emergency Room (ER) and then on to another hospital for surgery. The resident was admitted to the facility on March 11th for skilled care. The therapist had this resident ambulate with assist of 1. Our staff had the resident transferring/ambulating with 1-2 staff. The resident wasn't really walking much. The resident may have walked from her bed to her bathroom. Resident #1 was capable of wheeling herself in her wheelchair, but she did not wheel herself much. The resident was always a big walker when she lived at home. She would walk miles per day. On March 17 during the time frame between 12:30-1:30 a.m., she was found outside of the building. During our investigation, it was found the resident had a pretty good morning the day of the 16th. The resident worked very well with the therapist. The resident was confused, and was confused prior to coming to the facility, plus she had a brain bleed on top of that. Her day was uneventful. That evening she had gone to supper. She folded some laundry. Staff reported putting her to bed around 7:30 or 7:45, which was her normal time to go to bed. The nurse that was working the evening shift stated the resident had a quiet night. The nurse said the last time she had checked on the resident was 10-10:15 p.m.. The NHA stated at some point, at around 12:30 a.m., the night shift staff heard the door alarm sound. The staff looked out the big picture window to see if they could see anything and they	F 689		

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did not. Staff C, Certified Nurse Aide (CNA), was the one who disarmed the door. She punched the code and this reset the lock. Staff C didn't think there was anything wrong. Staff C and Staff D, CNA, noticed the resident wasn't there. It triggered them to think they had better check the door. They grabbed the flashlight to be prepared. They opened the door, there's a ramp to the left that goes down to a sidewalk. The NHA stated his understanding was the resident was laying at the corner, so when a person looks out the window you couldn't see very far. They brought the resident inside. Staff B, Registered Nurse (RN), did an assessment first and determined the resident didn't have any fractures. They brought the resident inside and put warm blankets on her. Resident had skin tears and abrasions on her feet. Staff B then called an ambulance and the resident was sent out. Staff B then called the NHA and the Director of Nursing (DON) to let them know what happened. Resident #1 had not tried to leave the facility prior to this. The resident really wasn't walking, just short distances from her bed to her bathroom. The resident had almost fallen earlier that afternoon (March 16th). NHA thinks it was from reaching out of her chair for something but the CNA was right there. The NHA thought the resident had on a night gown (hospital gown) and if he remembers right the resident had taken her gripper socks off. NHA stated Staff B had a conversation with the ER doctor who told Staff B a CAT scan showed a small brain bleed but there was no sign or trauma that the ER doctor could see indicating the resident had hit her head. The resident was admitted and they were deciding whether to do surgery again, put the resident on Hospice or have the resident come back to the facility in intermediate care. The NHA stated the resident

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did return to the facility on Hospice Care. The family came into the facility and wanted to visit about it. The Hospice nurse said she questioned if the resident should have been admitted to the facility the first time on Hospice. The NHA thinks it was 29 degrees Fahrenheit outside the night of the incident. The NHA said Staff C should have opened the door and surveyed the area outside. Staff C should have then, if she did not see the resident, start a head count. The CNA should have gone to the nurse and said I don't see anyone out there, let's do a head count. The nurse on the upper level would have called the nurse on the lower level and said we have a Code Purple so they could have done a head count down on the lower level to be sure no one from the lower unit got outside. The NHA stated as a result of this incident, they have done education, went over policy on elopement, the procedure of an elopement, walked through how a drill would work and then we actually ran the drills. NHA felt staff knew that's what we should have done. Staff was receptive to the education. NHA stated he/they made it clear what the result was going to be. He said they actually reassessed all residents for elopement. The NHA reported the facility checked all the doors and checked the Wanderguard. The NHA said Staff C had said the alarm was going off when she got there, she entered the code, looked out the window and saw nothing. Staff C received corrective action. Prior to this incident, the staff received annual inservices on elopement, and upon hire. The facility did a mass training and then those that weren't present for the mass training, the facility wouldn't let them go to the floor until they had the training, which required taking a quiz too. NHA reported the incident to Department of Inspection and Appeals. NHA stated they did not notify the

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F 689	Continued From page 10 police as they found the resident right away but would have notified the police if she was missing. The NHA stated there are 2 main doors, 1 on the upper level and 1 on the lower level. These 2 doors have the wanderguard on them. The other doors have keypads on them. The resident went through a keypad alarmed door. The Maintenance guys checked all the doors. NHA stated there are a total of 4 doors upstairs and 4 doors downstairs (exterior). NHA stated if you try to open the door the alarm will sound and the door will lock for 15 seconds. The door is open then until someone enters the code into the keypad. NHA added that currently because of the Coronavirus pandemic, the lower level main door is locked too. In an interview on 3/24/20 at 6:45 p.m., the DON stated she had been at the facility for about 6 months. The DON said on the night/early morning of the accident, she received a call about 1:30 a.m.. Staff B said there was an incident and she needed to know what to do next. Staff B told the DON they had found a resident outside. The DON said Staff B reported they did first aide, that an ambulance had been called and the resident was wrapped in blankets. Staff B stated she did not measure the skin tears as she was more worried about getting the resident warm. Staff B had gotten the blankets out of a warming drawer, Staff B had told DON the resident aroused to painful stimuli when the resident was outside. Once the resident was back inside and started to get warmed up, the resident started to come around. DON stated the ambulance came and the resident went to the hospital. Staff B had contacted the resident's family who were going to meet the resident at the hospital. Staff B called the DON back and stated that she was down the	F 689		

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200 hall and Staff C and Staff D were down the 300 hall. Staff C and D went to answer a call light down the 100 hall. DON stated the staff were unsure how long the alarm was sounding. Staff C looked out the window and did not see anything. Staff C then disarmed the door and assisted the resident who had their call light on. The DON said Staff B had been doing temperature checks on all residents because of the Coronavirus. When Staff B got to Resident #1's room and noticed the resident was missing, Staff B asked Staff C and Staff D if they had gotten the resident up. That's when Staff C had said oh my gosh, the alarm went off. They then grabbed a flashlight and went outside. That's when they found the resident, just around the corner, on the side of the building, on the sidewalk. Staff B did an assessment and the CNAs went and got a wheel chair. They then got the resident inside, got her in bed, wrapped her in warm blankets,and initiated emergency personnel to the building. DON said at this point is when Staff B called her. The DON stated she was on a speaker phone. She asked what happened. The DON emailed procedure and policy, went over what went wrong. Staff B went over the policy and did a mock drill and had the staff sign that it was done. The DON sent corrective action for Staff C. Staff B had Staff C review and sign. The following day after that we completed re-education of the policy, read through, went over what a drill should look like, went over the incident, what was learned and what went wrong. The facility looked at the doors and made sure they were working right/loud enough. The facility decided the issue was that Staff C only looked out the window, she should have gone outside and if no one was found outside then she should have started a head count. DON stated Staff C was

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aware of the policy. Staff C had said that door had been going off during the night and they called maintenance about a month ago or so, Staff C thought maybe that was happening, so that is why when she looked out the window and saw no one out there she thought it must have just been a door issue. The facility did elopement drills, one that night, one on dayshift and one on the evening shift. Everybody participated then completed quizzes. The DON stated the charge nurses are catching anyone that had not received education at report time before the staff would go out to work on the floor. There was a plan in place to start monthly elopement drills but the COVID 19 came into play. The facility already had an elopement drill scheduled for the week after this happened prior to the incident. This resident was not very mobile. The resident was not identified as an elopement risk. She was not exit seeking or anything like that. The resident returned to the facility on Saturday, 3/21/20. The resident has not attempted to self transfer. The DON stated the daughter has been sitting with the resident quite a bit. The DON stated the family wanted answers about all that happened and the family questioned a chair alarm The facility is a no alarm facility. The family agreed to using a motion sensor. The sensor is affixed to her cane and can be angled to where it needs to be.

In an interview on 3/24/20 at 9:04 p.m., Staff E, Licensed Practical Nurse (LPN), stated she worked the evening shift on 3/16/20. Staff E reported she was there until 10:30 to 11:00 p.m. Staff E stated the resident was in bed when she left. Staff E said the resident ate supper and sat in the solarium where the resident folded clothes. Staff E stated Resident #1 went to bed around

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F 689	Continued From page 13 7:45 that evening. The last time Staff E checked on her was around 10-10:15. Staff E stated she does hall checks so she can report to the oncoming shift that all residents are accounted for with their call lights within reach. In an interview on 3/24/20 at 9:17 p.m., Staff G, Certified Medication Aide (CMA) stated Resident #1 one minute could stand well and the next minute she could not. Staff G stated she would see the resident mainly in a wheelchair or a recliner. Staff G stated from what she understands this resident used to walk all the time. Staff G stated that you could tell Resident #1 didn't really like sitting. At times the resident would lean forward a little bit or inch forward a little bit (in her wheelchair or recliner). In an interview on 3/24/20 at 9:28 p.m., Staff F, CNA, stated she worked with Resident #1 prior to this incident. Staff F stated the resident transferred with the assistance of 2 staff but Staff F stated she hoped this resident could be changed to a 1 staff assist with transfer if she was doing well enough. Staff F stated the resident has been a 2 person transfer since her return to the facility. Staff F had never noticed resident walking independently. Staff F stated she had seen resident sitting on the side of her bed putting on shoes. Staff F stated resident was/is confused and unpredictable. In an interview on 3/21/20 at 10:05 p,m,, Staff C stated the night of the incident she heard a noise but it was not like a loud buzzing noise. It wasn't like the normal beep beep beep. The noise was soft and constant. Staff C stated she almost thought it might have been a hearing aide. Staff C stated she didn't even think of the noise as	F 689		

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being a door alarm because it wasn't loud and it usually goes off at the nurses station. Staff C stated there is a box at the nurses station that you can see a light that would tell you that a door is open. There wasn't anything going off at the nursees station. Staff C stated when she first got to the nursees station she asked Staff D what that noise was. Staff D was sitting in front of the box. Staff C stated there was no light on the box indicating the door had been open. Staff C stated they both (Staff C and Staff D) then walked down the hall following the noise. Another resident down that hall had her light on. They thought the noise may have been an oxygen tank. Staff D went into the other resident's room to answer the call light. Staff C then wondered why the door was buzzing after identifying the door was making the noise. Staff C pushed on the door to see if it was latched and it was. Staff C then entered the code into the keypad at the door and the buzzing noise turned off. Staff C stated she looked out the window and didn't see anybody and added it was dark out there. Staff C stated it was around 1:00 a.m., maybe even a little before 1. It took them (the ambulance) a little over an hour to get here and they got here at 2:00 a.m. Staff D went back to the nurses station and Staff C and D started to chart. Then Staff B went to take temperatures on the residents in the 100 hall. Staff B came back to the nurses desk and asked where Resident #1 was. Staff C thought this happened right around 1:00 a.m.. Staff C told Staff B that she heard the door buzzing. They looked in a couple of rooms and then went out the door and down and around the corner where they found Resident #1. Staff C stated she came back to the door and it was locked. Staff D was still in the 100 hall so let Staff C back in. Staff A who had just come to work, helped us. Staff C

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and D stayed and held the door. The resident was picked up, put into w/c then put into bed. Warm blankets were placed on the resident and Staff B called the ambulance. Staff C stated Resident #1 was not talking. Staff C stated the last time she had seen the resident was a little bit after 10:30 p.m, when she had seen the residents in her room. Staff C stated the door alarms don't sound very often on night shift. Sometimes they do go off when it's windy. The wind catches them. Staff C stated she just wished she would have gone outside when she heard the noise. Staff C stated after this happened she told Staff B the door was not buzzing like it should have been, that Staff C could barely hear it, and the light did not come on the box at the nursing station. Staff B then went and checked all the doors. Staff C stated she thinks they sounded normal in the front. She remembered nodding to Staff B down the other hallways that the alarms were going off. Staff C said none of the red lights went off at the nursing station and this had never happened while Staff C was on duty. Staff C filled out a maintenance form to have the lights checked. Staff C said if the light had been working it would have alerted me that someone was trying to get in the door or go out the door. And it wasn't the normal buzzing. Staff C added staff should be able to hear doors that are buzzing in other hallways at night because it's so quiet. Staff C stated Staff C and D were down the 300 hall doing rounds before hearing the buzzing noise at the nurse's station. Staff C stated she had no idea the door was making the buzzing noises. Staff C said the noise, the door alarms make, is usually very distinct and loud. Staff C said staff can usually hear another call light going off in a different hall. Staff C again stated she did not hear the buzzing noise until they got to the

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F 689	Continued From page 16 nurse's station. A Point of Care Audit provided by the DON, revealed Staff C charted on another resident on 3/16/20 at 11:39 p.m. An interview on 3/24/20 at 10:35 p.m., Staff B stated it was like 1:30 in the morning. She was going down the hallway to take temperatures and Resident #1's room is the first one she had gone into. Staff B stated the resident was not in her bed, the resident's sheets were rumpled and the resident's gripper socks were in the bed along with her pad. Staff B checked the resident's bathroom and the resident was not in it. Staff B then went to the nurse's station where the 2 CNAs were and asked Staff C and Staff D where the resident was. They stated they had not brought the resident out of her room. All 3 of them started looking through rooms. Staff B said Staff C then asked Staff D if she thought that alarm was the resident. Staff B asked what alarm. They responded it was the 100 hall door alarm. Staff B ran toward the door and entered the code, went out and it was pitch black. One of the CNA's let her back in the door as it locked behind her. Staff B ran and got her flashlight, entered the code into the keypad, went outside, went out the door and around the side of the building and found the resident there lying there on her left side. Staff C was with Staff B. Staff A, CNA had just come in to work as she always comes in early. Staff A went outside when Staff C went inside to get the wheelchair which Staff B had told Staff C to go and get. The resident had a strong pulse but was not responding. The resident was breathing Staff B stated the resident may have been shivering but she didn't know because Staff B was shaking so bad. The	F 689		

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resident had been drooling. The resident had some abrasions. Staff C brought out w/c and they 2-man lifted the resident into the wheelchair. There were no foot pedals so Staff B held on to the residents legs and they reverse pushed her back into the building and into her room. Staff B requested for staff to bring her the vital signs machine. Staff B stated the resident's arms were cold. Her pulse was 95, her blood pressure was high, and her oxygen saturation was good. The resident's temperature reading was "LO" meaning it was too low to get a reading. Staff A brought heated blankets and they wrapped the resident from head to toe except for the resident's face. Staff B called a doctor, explained the situation and got the order to send the resident out by ambulance. Staff B then called 911 and then called the DON to ask how to proceed from there. Staff B started asking Staff C and Staff D what happened. Staff C and Staff D stated they heard the alarm but it was very quiet like a hearing aide. They thought it was the deck door, or the utility door, but they tracked the noise down to the end of the hallway. Staff D answered another resident's call light and Staff C said she looked outside, didn't see anybody so she shut the door. Staff B stated they just went on with their night. Staff B said they had a box at the nurses station. Staff C and Staff D said it had not gone off. Staff B tried the 100 door with the keycode and the box didn't go off. Staff B did the same without the keycode, pushed on the door for 15 seconds and the door will let you open it. The box did not buzz and the light did not go on. The alarm on the 100 hall door was quiet. That one was not as loud as it should be. Staff B then checked the 200 hall and 300 hall, dining room, and main doors. The box did not go off for any of the doors. Staff B said the box has been removed since that night.

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Staff B stated when the box was present in the nurses station you could hear it alarm in all halls and would know to look at the box. Staff B said there was no way you could have heard the alarms that were functioning at the time of the incident from another hall because that night the box wasn't working. Staff B stated the door alarms have gone off before when it was really windy outside because the wind would catch the door and set the alarms off. Staff B stated this is how she knows the alarm box was so loud because the door alarms being set off by the wind has happened before. Staff B stated she thinks that is what Staff C and Staff D thought, that the wind had caught the door. Staff B said she doesn't even know if it was windy the night of this incident. Staff B said it was cold though. Staff B stated the resident had on a green hospital gown. Staff B said there is a light outside the 100 door now but the night of the incident it was burned out. It was replaced the next day.

An observation on 3/24/20 at 11:00 p.m., revealed the Resident #1 lying in her bed. The 100 door was shut and light was shining outside of the door.

In an interview on 3/25/20 at 11:46 a.m., Staff D stated Staff C and herself were doing their 10:30 rounds. She stated they were working down the 300 hall. Staff C went to the desk (nurses station) and Staff D went to the bathroom. Staff D stated it takes about 2 ½ to 3 hours to do the 10:30 rounds. Staff D it was around 1-1:30 when the incident occured. Staff D came out of the bathroom to the nurses station Staff D asked Staff C what was that noise. Staff D said it was like a constant steady beep, Staff D said she had not heard that noise before but it almost sounded

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like someone's oxygen machine when it gets low. Staff D and Staff C started walking the 100 hall and the noise started getting louder. Staff D said they could not hear the noise from the 300 hall, it was at the nurses station where they first heard it but it was very faint. Staff D said they couldn't hear it very well as it wasn't a very loud noise. They started walking down the hall and when they got to the end of the hall they could tell the noise was coming from the door. The door wouldn't open, so Staff C pulled on the door and it shut. Staff D turned and answered the call light that was going off in another resident's room. Staff D stated Staff C had looked through the window but did not see anything. Staff D stated there was no light on the outside. Staff D stated it was pitch black out. Staff D stated there was a central box at the nurses station and it had switches on it. Staff D remembered it being there from a long time ago as well, when she worked from 2011 to 2015. Staff D said the box would sound loudly. There's a light above each switch. There were not any lights on the box nor was the box making any noise the night of the incident. Staff D stated it didn't even cross her mind to do a headcount because Staff D didn't think that's what it was. Staff D stated she thought the door was malfunctioning because the box didn't light up or make a sound. Staff D stated after that they started doing their charting, Staff B was taking temperatures and that is when it was discovered the resident was not in her room. Staff D stated she said you don't suppose - the door? The resident was found outside. Staff D stated the resident couldn't walk by herself and required the use of a walker and assist of 2 staff. Staff D said they would have never thought the resident could have made it down to the end of the hall by herself with or without a walker. Staff D said the

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resident would sit on the edge of her bed but that was about it. Staff D stated if the box would have been working they would have heard it from anywhere because it was really loud Staff D stated it was about 10:30-10:45 p.m. when they saw this resident last, on rounds, Staff D stated this resident is one of the first residents they check, Staff D stated when she went in on Sunday March 22nd the box was gone and they had installed a light outside the 100 door.

In an interview on 3/19/20 at 11:00 a.m, Staff A stated she had come to work at 1:30 a.m. the morning of 3/17/20. Staff A did not see the resident at that time. Staff A went out with Staff C to assist getting this resident back inside. Staff A stated it was dark and cold outside, about 20 something degrees Fahrenheit. Staff A reported the resident was laying on the sidewalk with her head in the rocks and her legs in the grass. Staff A stated the resident had only a hospital gown on without under garments. The resident was barefoot, her arms were pulled up to her chest, her lips were quivering and her legs were purple. The resident was unable to verbalize and was not responsive. Staff A, B , and C got Resident #1 into the building and in bed, put warm blankets on her. EMS (911) was called at 1:40 a.m. after Staff B had taken vital signs. Staff A stated the resident had been outside for around 40 minutes.

An Employee Time Card provided by the DON, showed Staff A clocked in on 3/17/20 at 1:30 a.m. It also documented Staff A helped with fall.

An observation and interview on 3/25/20 at 2:30 p.m., NHA checked all alarmed doors on the upper and lower floors. All alarmed doors

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F 689	Continued From page 21 sounded. NHA stated a new system was installed that morning on the upper floor. The new system is a back up panel and they have had the one downstairs for 5 years. He stated the old system was outdated and obsolete. NHA stated they had gotten quotes for a new system and it was approved last Monday or Tuesday (March 16th or 17th). The 100 door sounded when engaged, the latch released after 15 seconds and the door remained on until the keycode was entered and the door was locked. At the time the alarm was activated the newly installed back up panel located at the nurses station in the middle of the halls stated "alarm and activity detected 100 door". The 100 door alarm was left on during the time the other upper level doors were checked. The back up panel could be readily heard from all hallways. The lower level doors and back up panels all functioned properly and could be heard throughout the lower level. In an interview on 3/25/20 at 3:30 p.m., Staff H, Environmental Services Director (ESD), stated the 100 door alarm sounded different when it was checked after the incident. He stated all doors sounded. Staff H stated the first time he became aware of the staff not being able to hear the door alarms from other hallways was after this incident. Staff H confirmed the central unit located at the nurses station at the time of the incident was down. Staff H stated the door issues he was aware of prior to this incident had to do with the wind blowing a door disconnecting the magnetic connection and setting the alarm off. He believed the last time this had happened was in December. He said it was about a five minute fix to adjust the turn style knob on the magnetic lock, it required enough pressure on it so the wind wouldn't disconnect the magnetic	F 689		

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F 689	Continued From page 22 connection. In an interview with the NHA at the same time (3/25/20 at 3:30 p.m.), the NHA stated they had installed white pull away sensors on the doors upstairs on Friday March 20th, after learning the staff could not hear the door alarms on 3/17/20. NHA stated they had to acquire the pull away alarms first prior to applying them to the doors. NHA stated they did not change other procedures/processes between when the incident happened and when the pull away alarms were added on Friday, other than re-educating all staff. The NHA stated the facility had put in a request for a new central unit as the one on the upper level was old and the facility could not order parts for it anymore. The NHA stated the central system was a back up system to the door alarms. In an email dated 2/24/20 at 11:13 a.m., revealed correspondence of request for a quote, for the upper unit to have an identical system to the lower unit. A form dated 2/24/20 titled 1st Floor Nurse Alarm, showed an approval and order date of 3/18/20. An observation on 3/26/20 revealed the resident sitting in the common room with a male visitor. Noted motion sensor device attached to the resident's cane. An email from the State Climatologist of Iowa dated 3/31/20 at 12:57 a.m., documented the observations from 1:30 a.m. CDT on March 17, 2020 from Algona Municipal Airport were: Temperature: 28 degrees Fahrenheit, Winds were out of the west-northwest at 8 mph, the	F 689		

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F 689	Continued From page 23 Wind Chill temperature was 20 degrees Fahrenheit. A Progress Note dated 3/21/20 at 9:30 a.m., documented Resident #1 was discharged from the hospital with Hospice care. Daughter accompanied resident at time of admission and resident was able to transfer with the assist of 2 into bed. The entry documented wander-guard usage. A Progress Note dated 3/21/20 at 11:38 p.m., documented the resident had been restless that night and the alarm by bed was sounding. A Care Plan with a revision date of 3/17/20, directed staff the resident was to wear a Wanderguard. Review of the Policy and Procedure for Elopement dated 4/16, stated that purpose is to: *Asses and identify residents at risk for elopement *To clearly define the mechanisms and procedures for monitoring and managing residents at risk for elopement. *To provide a system of documentation for the prevention of, and in an event of, elopement *To minimize risk for elopement through individualized interventions *To provide staff members with education on elopement at orientation and at least annually *To identify a plan in the event of resident elopement *To provide protection for residents at risk for elopement Policy included:	F 689		

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	165190	A. BUILDING _____ B. WING _____	C 03/31/2020

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F 689	Continued From page 24 *The location will be responsible for maintain a system that clearly defines the mechanisms and procedures for monitoring and managing residents at risk for elopement. These include identifying environmental hazards and residents risks: evaluating/analyzing hazards and risk: implementing interventions; and monitoring/modifying interventions as needed. *All residents will be assessed for risk of elopement through the pre-admission and/or admission process and as needed. Each location will put measures in place to minimize the risk of elopement that are individualized to resident needs and identified on the care plan. When an elopement occurs, immediate efforts to locate the resident will be taken. All occurrences will be documented and all follow-up required by state and federal regulations will occur. *Careplan team members should consider the following when assessing risk for elopement: *wandering behavior- the movement may be goal-directed (the person appears to be searching for something such as an exit) or may be non-goal directed or aimless. Non-goal directed wandering requires a response a manner that addresses both safety issues and a evaluation to identify root causes to the degree possible. Moving about the location aimlessly may indicate that the resident is frustrated, anxious, bored, hungry or depressed. Unsafe wandering and elopement can be associated with falls and related injuries. *History of elopement *Cognitive impairment *Attempts to leave location *Residents who are new admits to location *Recent alteration in residents mental status without a history of previous cognitive impairment to include memory loss, decrease awareness and	F 689		

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F 689	Continued From page 25 disturbances in judgement, reasoning and perception. A Missing Resident Procedure added for staff education on 3/17/2020, directed staff that each and every time a door alarm goes off ALL staff irregardless of position or department is expected to respond to the alarm and to determine why the alarm went off. The immediate area outside the door which is sounding must be checked to ensure no resident is out there. If there is no immediate known reason why the alarm sounded a head count MUST be done to ensure all residents are present and accounted for. Staff must treat each door alarm as if there is a concern. The nursing assistant report sheets can be used to account for all residents. Place a check mark next to their name once they have been identified. These then need to be dated and turned into the DNS. The facility abated the immediate jeopardy on March 20, 2020 by educating all staff what is expected when responding to a door alarm and to determine why the alarm went off along with installing white pull away sensors on the upstair doors to ensure staff could hear when a door had been opened until the new back up door alarm panel was installed on March 25, 2020.	F 689		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.	F 712		

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F 712	Continued From page 26 §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure 2 out of 3 residents reviewed (Resident #2 and #3) received timely physician visits at least once every 60 days and no later than 10 days after the visit is required. The facility reported a census of 73. Findings include: 1. A Minimum Data Set (MDS) dated 12/26/19, documented diagnoses for Resident #2 included; dementia, depression and acquired absence of left leg above knee. A Brief Interview for Mental Status (BIMS) showed a score of 7 out of 15, indicating a moderate cognitive impairment. Resident #2 required extensive assist of 2 staff for bed mobility and transfer. The resident required extensive assist of one for locomotion on and off the unit. Office Clinic Notes dated 8/19/19, documented this resident was seen for a nursing home check.	F 712	F712 Resident #2 and #3 are up to date with their physician visits and orders reviewed. This has the potential to affect all private pay residents. Nurse managers educated on 4/13/2020 on the physician visit requirements by DNS and administrator. Audits will be conducted on all private pay residents to ensure compliance. Audits will be assigned by QAPI and conducted bi-weekly x1, then monthly x1 by designated staff. Findings will be brought to QAPI committee. QAPI committee will review findings and determine to continue or discontinue audit.	

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F 712	Continued From page 27 Office Clinic Notes dated 3/16/20, documented this resident was seen for Medicare wellness. 2. A MDS dated 12/17/19, documented diagnoses for Resident #3 included diabetes, dementia, and depression. A BIMS showed a score of 7 out of 15, indicating moderate cognitive impairment. Resident #3 required extensive assist of 1 staff for bed mobility. The resident required supervision for transfers and locomotion on and off the unit. The resident's admission date is documented at 6/13/2019. Office Clinic Notes dated 7/8/19, documented this resident was seen for her 1st 30 day visit. Office Clinic Notes dated 8/7/19, documented this resident was see for her 2nd 30 day visit. Office Clinic Notes dated 9/11/19, documented this resident was seen for her 3rd 30 day visit. Office Clinic Notes dated 3/16/20, documented this resident was seen for a 60 day visit. During interview the Nursing Home Administrator (NHA) stated the facility could not produce any further 60 day visits other than the ones above for the period of 6/2019 to 3/30/20 for either Resident #2 or Resident #3. NHA stated other visits or documentation could be produced such as emergency room visits, wound care visits and answers to a gradual dose reduction request but not the required 60 day physician visits. NHA stated the facility should have a procedure in place to guarantee these visits get done. NHA stated the facility will be putting something together. The NHA stated the nurses should have	F 712		

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F 712	Continued From page 28 been tracking these on an Excel sheet.	F 712		