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F 000	INITIAL COMMENTS Correction Date______________________ On August 10 - September 30, 2020, an investigation was conducted regarding facility reported incidents, 87665-I and 90793-I and complaints 86623-C, 87094-C, 87118-C, 87058-C, 87088-C, 89791-C, 93282-C, 93220-C, 93075-C, 92744-C, 92629-C, 92465-C, 90636-C, 92396-C, 90799-C. The following complaints and facility reported incidents were substantiated: 87665-I, 90793-I 86623-C, 87118-C, 87058-C, 87088-C, 89791-C, 93282-C, 93220-C, 93075-C, 92744-C, 92629-C, 92465-C, 90636-C, 92396-C Complaints 87094-C, and 90799-C were not substantiated. In conjunction with the complaint and facility reported incident investigation, a COVID-19 Focused Infection Control Survey was also conducted by the Department of Inspections and Appeals. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19 at the time of the investigation. The facility census was 56 residents. Amended 12/3/20	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence,	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/24/2020

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 550	Continued From page 1 self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 550		

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Based on observation, record review, and resident and staff interviews, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident ' s individuality when they failed to place a resident's call light within reach for 1 of 3 residents reviewed (Resident #14). The facility reported a census of 55 residents.

Findings include:

According to the Minimum Data Set (MDS) assessment tool dated 8/13/2020, Resident #14 had diagnoses that included seizures, depression, psychotic disorder, obesity, lymphedema and trauma to left cerebrum. The MDS documented the resident scored 11 on the Brief Interview of Mental Status (BIMS) test, which meant the resident demonstrated moderately impaired cognition. The MDS also documented Resident #14 required extensive assistance of 2 staff for bed mobility, transfers and locomotion within facility, experienced impairment to bilateral (both) upper extremities (shoulders, elbows, wrists, and hands), and utilized a wheelchair. The MDS revealed she received a diuretic for 7 days during the 7 day review period, which resulted in increased trips to the toilet to eliminate the excess fluid.

Review of the care plan revealed the resident had potential or actual increased fluid volume due to lymphedema (localized swelling of the body caused by an abnormal accumulation of lymph) in bilateral legs and the use of a diuretic. The care plan documented the resident also experienced a

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self-care deficit related to a brain injury, weakness, and jerky unsteadiness of extremities and was also at risk for falls (initiated date of 8/7/2017 with a revision date of 2/8/2019). The care plan directed staff to implement the following interventions:

1. On 11/20/17 - Resident #14 required assistance of 2 for toileting, is frequently incontinent of urine and occasionally of bowel. The care plan indicated she does drink a lot of fluids (pop) all day and will have increased incontinence because of this. Initiation date of with a revision date of
2. On 2/8/19 - Place call light within reach
3. On 1/28/20 - Assist the resident to the commode as requested utilizing with 2 staff.
3. On 11/1/19 - Please push Resident #14 in her wheelchair to and from the dining room at meal times as it is difficult for her to propel herself independently due to her medical condition.

During an observation on 9/1/2020 at 11:56 AM, Resident #14 yelled, "My call light is on, come help me." Closer observation revealed the resident's call light had not been activated. The resident sat in her wheelchair to right of her bed with a bedside table in front of her, call light not in reach. The call light lay in the middle of her with a stuffed animal tied to the end of it.

Observation on 9/1/2020 at 2:10 PM revealed Resident #14 yelled for help, although her call light was not activated. Two staff walked by the resident's room at that time and did not respond to the resident's call for help. The resident sat in her wheelchair with her call light on the bed and out of the resident's reach. She stated, I can't reach that call light and I have to go to the

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F 550	Continued From page 4 bathroom. They always do that to me. The surveyor proceeded to activate the resident's call light and staff entered the room to assist her. Observation on 9/1/2020 at 2:22 PM revealed resident sat in her wheelchair to the right of her bed with her call light out of reach on her bed. Observation on 9/16/2020 at 11:30 AM revealed Resident #14 sat in her wheelchair to the right of her bed, with her bedside table in front of her while she watched television. The call light lay on her bed with a stuffed animal tied to the end of it and beyond her reach. In a follow-up observation at 12:25 PM, Resident #14 sat closer to the sink eating her lunch on a bedside table with her back toward her bed and call on her bed out of reach. At 12:53 PM the resident sat in the same position, and at 1:30 PM, her call light remained out of reach on her bed. The resident again sat in her wheelchair to the right of her bed. During a resident interview on 9/1/2020 at 2:40 PM, Resident #14 stated she does use the light a lot because she is on a water pill so she goes to the bathroom a lot. During a staff interview on 9/22/2020 at 4:55 PM Staff Z CNA was asked where to place the call light prior to leaving a resident in their room, she stated staff should place the call light within the resident's reach. When asked if that also included cognitively impaired residents, she answered in the affirmative. During a staff interview on 9/22/2020 at 6:11 PM Staff EE CMA/CNA was asked where she would place a resident's call light before leaving their room. She stated she always put it within reach	F 550		

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F 550	Continued From page 5 so the resident could access it, for example, on the bedside table or wrapped around the bed rail). . During a staff interview on 9/24/2020 at 12:30 PM the Director of Nursing (DON) was asked where should a resident's call light be placed before staff leave a resident's room. The DON stated before they leave the room, staff should ensure the resident's call light is reach at all times. If the cord is too short, she would ask the maintenance person to attach a longer cord. Review of the use of a call light policy revealed, in part: when providing care to residents, staff are to ensure they conveniently positron the call light for the resident to use.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		

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accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and family interviews, and facility policy review, the facility failed to investigate and report an injury of unknown origin and a resident-to-resident incident to the Department of Inspections and Appeals as required. On 9/23/19, a Certified Nursing Assistant (CNA) told the nurse they found Resident #1 crying in her bed. The nurse assessed the resident and sent her to the emergency room where an X-ray idnetified left wrist and left femur fractures. The facility also failed to report a resident to resident incident to the State Agency as required. On 12/21/2019, Residents #15 and #17 were found in the back dining room kissing and Resident #15 had her hand down Resident #17's shirt. The facility reported a census of 56 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment tool dated 8/22/19, Resident #1 had diagnoses that included diabetes mellitus, Alzheimer's disease, fracture of left pubis and knee cap and unspecified injury of head. The MDS documented the resident displayed severely impaired cognitive skills and required extensive

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F 609	Continued From page 7 assist of 2 staff for bed mobility, transfers, and walking. The MDS revealed Resident #1 had 1 fall since admission that resulted in a major injury. The care plan with an initiated date of 9/21/2018 and a canceled date of 1/9/2020 documented the resident as at risk for falls related to dementia, antipsychotic use, type 2 diabetes, and narcotic use. A Morse Fall Scale assessment dated 8/22/2019 identified the resident as at low risk for falls. A progress note documented on 9/23/2019 at 2:30 AM, a CNA told Staff T, Licensed Practical Nurse (LPN) they found Resident #1 crying in her bed. Staff T's assessment revealed the resident presented with a purplish blue, swollen, and puffy left wrist, a left hip bone that was sore to touch, and left leg shorter than the right. Staff T called the resident's primary physician and received an order to transport her to the local hospital for evaluation. A hospital Patient Discharge and Transfer Form documented the primary discharge diagnoses as left femur IM nail on 9/23/2019 and left wrist fracture. The State Agency was contacted on 8/18/2020 at 2:30 PM and verified the facility failed to report this incident to the Iowa Department of Inspections and Appeals as required. Review of the Department of Inspections and Appeals online reporting program revealed the facility did not submit the incident through the reporting program.	F 609		

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During a staff interview on 8/25/2020 at 10:30 AM the Director of Nursing (DON) stated they could not find an investigative file for Resident #1 related to her injuries of unknown origin.

In an interview on 9/24/2020 at 12:30 PM the DON verified, when asked, that this injury of unknown origin should have been investigated by the facility and then reported to the Iowa Department of Inspections and Appeals, although she was not the DON at that time.

2. According to an MDS dated 11/10/2019, Resident #15 had diagnoses that included thyroid disease, non-Alzheimer's Disease, multiple sclerosis, anxiety, and depression. The MDS documented the resident scored an 8 on the Brief Interview for Mental Status (BIMS) test, which meant the resident experienced moderate cognitive impairment. The MDS indicated Resident #15 required limited assistance of 1 staff for bed mobility, transfers, and walking, used a walker and a wheelchair for locomotion, and displayed physical behavioral symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal behavioral symptoms directed toward others (threatening others, screaming at others, cursing at others) on 1 to 3 days during the 7 day review period.

According to the MDS dated 9/26/2019, Resident #17 had diagnoses that included other mental disorders due to known physiological condition and obesity. The MDS documented the resident scored 0 on the BIMS, which indicated she experienced severe cognitive impairment. The MDS documented the resident experienced

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delusions as a potential indicator of psychosis, required limited assistance of one staff for bed mobility and transfers and did not require a mobility device.

Review of Resident #17's record revealed on 12/21/19 at 5:44 PM, another resident reported to staff that this resident was in the dining room kissing Resident #15. Staff went to the dining room and found her kissing another resident on the lips and the other resident had her hand down Resident #17's shirt. Staff separated the residents and notified the family, physician, local police and Administrator.

Review of Resident #17's clinical record revealed it lacked an investigation related to the 12/21/19 incident that also involved Resident #15.

In email correspondence on 9/2/2020 the DON reported she could not locate an investigative file for this incident.

In a follow up interview on 9/23/2020 at 3:48 PM the Director of Nursing (DON) was asked for an incident report and investigative file for the incident between Resident #15 and #17. She stated all she could find were the progress notes. Review of Resident #15's clinical record revealed it lacked an investigation related to the incident that took place on 12/21/2019.

In an email correspondence on 9/23/2020 at 4:23 PM, the Regional Manager was asked for an investigative file for the incident between Resident #15 and #17. He replied they could not find any investigation file for this incident.

When the DON was asked why the facility did not

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F 609	Continued From page 10 report and/or investigate the incident, she stated it happened when another Administrator was here and believes it was an oversight. Review of the facility's Abuse Prevention, Identification, Investigation, and Reporting Policy with a revision date 11/28/2016 revealed a policy statement: All residents have the right to be free abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Review of the facility's Abuse Prevention, Identification, Investigation, and Reporting Policy with a revision date of 11/28/2016 revealed injuries of unknown origin should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting to the Administrator or designated representative. Injuries of unknown origin shall be reported to the Iowa Department Inspections and Appeals, no later than 2 hours after the injury has been identified.	F 609		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		

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This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to provide nursing care according to accepted professional standards for 1 of 5 residents reviewed (Resident #24). The facility reported a census of 56 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment tool dated 6/18/20, Resident #24 had diagnoses that included traumatic subdural hematoma, fractured skull, post concussional syndrome, dementia, hypertension, and constipation. The resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which meant the resident displayed intact cognition. The MDS documented the resident as independent with ambulation (walking) and transfers and as always continent of bowel and bladder.

According to the facility form, Weights and Vitals Summary, for the months of April, May, and June 2020, Resident #24 had the following elevated readings (blood pressures that exceeded SBP of 139 and DBP of 89):

a. April 2020: 1 episode of elevated SBP and 1 of DBP
b. May 2020: 11 episodes of elevated SBP and 4 DBP
c. June 2020: 13 episodes of elevated SBP and 7 DBP

Review of nurse to physician notifications for April, May, and June of 2020 revealed no entries in either the hard chart or the EMR that showed

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staff attempted to notify the physician or care provider of Resident #24's elevated blood pressure results.

When asked during an interview on 8/12/20 at 1:00 p.m., the DON explained systolic blood pressure (SBP) that exceeded 139 and a diastolic blood pressure (DBP) that exceeded 89 were high values. She added she would expect the nursing staff to notify the physician of any readings that fell outside of normal parameters.

During an interview with Staff F on 8/13/20 at 9:32 a.m., she stated she checked blood pressures of residents before administering antihypertensive medications and reported the chart typically provided parameters to direct staff when to hold a medication. She stated she would notify the doctor via phone or fax of an elevated blood pressure with a value greater than 140/85-90. She added if she notified the doctor by phone she would document it in the progress notes; if the notification occurred by fax, she would file the fax sheet in the physical or "paper" chart (hard chart).

2. A physician order for Resident #24 dated 3/12/20 at 7:03 p.m. directed staff to give Lisinopril 20 mg daily for hypertension (HTN) and hold the medication if blood pressure is less than 100/60.

Record review of the Medication Administration Record (MAR) revealed staff administered Lisinopril to Resident #24 without taking a blood pressure 14 times in March (16-18, 20-25, 27-31) and 13 times in April (1, 3-8, 10-15).

During an interview with Resident #24 on 8/11/20

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at 1:00 p.m., he reported the facility is supposed to check his blood pressure twice daily but they do not do so. He also commented the facility took away his automatic cuff his family brought from home.

During an interview with Staff F on 8/13/20 at 9:32 a.m., she reported she checks blood pressures of residents before administering antihypertensive medications. She stated she thought all nurses would know they needed to do this.

During an interview with the DON on 8/12/20 at 1:00 p.m., she reported the facility expectation was for staff to obtain a a full set of vital signs for each resident at least once per week, unless a doctor order or medication insert directed otherwise. She stated an example would be drugs that could affect heart rate or blood pressure, which normally required parameters to direct staff when to hold the medication. She stated in that case, she would expect staff to take those vital signs prior to administering the medication.

3. Progress notes dated 7/29/20 at 2:40 pm documented Resident #24 complained of constipation and chest pain. Staff sent her to the Emergency Room via ambulance on 7/29/20 at 3:04 pm.

Progress notes on 7/29/20 at 5:05 pm documented the facility received a phone call from the hospital that revealed hospital staff administered 2 Bisacodyl and a fleets enema and then had 2 large bowel movements (BMs)

The Hospital Emergency Room report dated

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7/29/20 documented Resident #24 had a moderately sized hard bowel movement and was discharged back to the care center with instructions to resume Benefiber.

Review of Medication Administration Record for the month of August 2020 shows no order for Benefiber two tablets once or twice daily as needed to produce a bowel movement at least every other day.

In an interview on 8/12/20 at 2:30 pm, the DON stated staff should implement and follow physician orders in a timely manner.

Review of Bowel Elimination Record from 7/13/20 thru 8/11/20 shows Resident had no BM from 8/3/20 to 8/6/20.

Review of the Medication Administration Record for the month of August 2020 reveled staff did not administer any Milk of Magnesia during the month of August.

In an interview with Director of Nursing (DON) on 8/12/20 at 2:30 p.m. she stated the facility did not have a policy or procedure for bowel management. DON states the facility is guided by the standard of care that directs give 30 cc of Milk of Magnesia on Day 3 of no bowel movement, give Bisacodyl suppository on Day 4 of no bowel movement, and notify the physician on Day 5 if there is still no BM.

Review of the MAR for days 8/3/20, 8/4/20, 8/5/20, and 8/6/20 revealed staff did not administer Milk of Magnesia or a Bisacodyl Suppository on those dates.

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and observations the facility failed to ensure residents received a bath at least once a week for 2 of 5 residents reviewed (Resident #23 and Resident #24). The facility reported a census of 56 residents. Findings Include: 2. The MDS dated 8/7/20 documented Resident #23 had diagnoses that included chronic ulcer of right leg, obesity, anemia, and atrial fibrillation and revealed the resident demonstrated intact cognition. The MDS also documented the resident required extensive assist of 2 staff for bathing and was totally dependent on 2 staff for transfers. The MDS revealed the resident experienced bladder incontinence. In an interview on 8/11/20 at 12:40 pm, Resident #23 reported they had been admitted to facility on 7/31/20 and has not had a bath or bed bath since admission. The resident reported she would like to have bath and for staff to wash her hair. Resident states she has asked for this and staff told her they would let someone know. Review of the bathing task report 30 day look back period verified the resident has not bathed.	F 677		

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F 677	Continued From page 16 During interview on 8/12/20 at 2:30 Director of Nursing (DON) stated every resident should be provided the opportunity to bathe at least twice per week. 2. According to the Minimum Data Set (MDS) assessment tool dated 6/18/20, Resident #24 had diagnoses that included: traumatic subdural hemorrhage, fractured skull, post concussion syndrome, dementia, and high blood pressure. The MDS documented a Brief Interview for Mental Status (BIMS) score of 10 (moderate cognitive impairment) and revealed the resident was independent with walking and transfers, remained continent of bowel and bladder, but required setup help with bathing. Review of the bathing task report 30 day look back period showed Resident #24 had a bath on 7/18/20. Review of bath aid sheets show Resident #24 received a bath on 7/2/20, 7/17/20, 7/24/20, and 8/4/20 which revealed a time period of 15 days in the first part of the month and 11 days in the last part of the month when the resident went without a bath. In an interview on 8/12/20 at 10:40 am, Staff E Certified Nursing Assistant (CNA) reported staff was hard at times and then the facility reassigned the bath aid to provide resident care. She added that baths not completed on the day shift should be made up on the night shift, but she is unsure if the baths get done.	F 677		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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§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 observations, record review, and staff interviews, the facility failed to provide adequate nursing supervision to ensure the environment was as free of hazards as possible for a resident with a history of attempted and actual elopement (when a resident leaves the building without staff knowledge or consent). Resident #4 was at high risk for wandering due to his history of elopement and elopement attempts. On 4/23/2020, an off-duty staff member found Resident #4 0.5 miles away from the facility as he walked back from a convenience store in town. After this incident, the facility implemented 1-1 supervision (having a staff member with the resident at all times). The investigation revealed the facility failed to consistently schedule enough staff for this level of supervision to ensure he did not again leave the facility unattended and without staff knowledge. These circumstances posed an Immediate Jeopardy to resident health and safety. The facility also failed to provide adequate nursing supervision on the memory care unit to prevent a male resident from being sexually inappropriate with a female resident. The facility reported a census of 56 residents.

Findings include:

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F 689	Continued From page 18 According to an admission Minimum Data Set (MDS) assessment tool dated 3/3/2020, Resident #4 had diagnoses that included: diabetes mellitus, schizophrenia, psychoactive substance abuse, chronic obstructive pulmonary disease, age-related cognitive decline, and transient ischemic attack ("mini-stroke"). The MDS documented the resident had a Brief Interview of Mental Status (BIMS) score of 7, which meant he demonstrated moderately impaired cognition. The MDS indicated Resident #4 had difficulty focusing and keeping track of what was being said to him and also displayed verbal behavioral symptoms directed toward others on 4 to 6 days during the 7 day review period. The MDS identified the resident wandered on a daily basis which placed him at significant risk of leaving the facility unattended and without staff knowledge. The MDS revealed Resident #4 required set-up assistance from staff for bed mobility, transfers, and walking in his room and adjacent areas. The MDS documented the resident required supervision of one staff for walking. Review of Resident #4's care plan revealed the following focus area with an initiation date of 2/25/2020: altered thought process related to diagnosis of schizophrenia and cognitive decline, history of substance abuse and chronic memory impairment, and reports of forgetfulness. The care plan listed another focus area with an initiation date of 3/6/2020: at risk for elopement related to the use of antipsychotic medications and impaired cognitive function. The care plan listed the following interventions: a. 3/6/2020 - Assess and document wander guard placement and function every shift	F 689		

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F 689	Continued From page 19 b. 4/23/2020 Resident eloped from the facility and refuses to wear a wander guard. Staff to provide 1-1 supervision through the weekend. c. 4/23/2020. Assess and avoid possible triggers for wishing to leave d. 8/4/2020: Potential for elopement related to resident voiced desire to leave the facility. e. Call family, if able, as the resident requests. f. Document all attempts to leave the facility. Increase physical activities as tolerated. g. Inform physician and ask for suggestions for interventions. h. Keep an updated picture of the resident on the Medication Administration Record. i. Maintain a calm attitude when assisting or redirecting the resident. j. Observe for restlessness and offer snacks and beverages, and/or provide diversion type activities such as coffee shop, TV, and activity department activities. k. The resident has been informed to not leave the facility without staff or family. l. Complete wandering assessment as needed and at least quarterly. * Further review during the investigation revealed Resident #4's care plan revealed it had not been updated by staff after he had eloped to a convenience store on 4/23/2020. Resident #4's care plan was updated on 8/28/2020 to include his elopement on 4/23/2020 (4 months after the incident). The care plan listed the following focus area with an initiation date of 8/4/2020: wandering related to impaired cerebral function secondary to dementia as evidenced by resident unable to find what he is seeking and pacing repetitively. The	F 689		

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care plan listed the following interventions:

a. Ensure routine pathways are clear of obstruction.
b. Place signs or labels to help identify locations he
might be seeking.

d. Provide a regular and scheduled walking program.
e. Provide for safe ambulation (walking) with comfortable and well-fitting clothes.
f. Provide shoes with non-skid soles and any necessary walking aids.
g. Redirect the resident by diverting attention to offerings of food, snacks, and drinks.

The care plan had a focus with an initiation date of 5/18/2020: the resident has the potential to be physical aggressive related to anger and history of harming others due to poor impulse control.

Review of Resident #4's clinical record revealed an admission wandering risk assessment dated 2/25/2020 and another dated 4/23/2020. Both assessments identified him as at high risk for wandering.

The progress notes contained the following entries:

On 3/3/2020 at 3:00 AM, staff documented the resident verbalized frustration because facility rules prohibited him from going outside to smoke at that hour. The resident raised his voice, used profanity, advanced close to the nurse in a threatening manner, and attempted to aim and throw a bottle of sanitizer at her. Two male CNAs then jumped in front of the nurse to block any

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F 689	Continued From page 21 attempts made by the resident to harm her. Resident #4 stated "I don't care about you or that b--ch, I'm going to knock her on her ass." He then advanced toward that CNA and the nurse grasping the sanitizer bottle in one hand and holding up his other fist in a threatening manner. The nurse tried to placate the resident and asked him to calm down and they would get clarification on the rule tomorrow. The resident then stated he was going to walk to Des Moines. He put on his coat, pushed the button, and walked out the front door with the nurse and a CNA following. The nurse then alerted the Director of Nursing (DON) and local law enforcement. The DON and 2 local law enforcement officers arrived and talked Resident #4 back into facility, although the resident kept asking them to either take him jail or give him a ride to Des Moines. After about a half hour, he finally went back his room. Once law enforcement left and the DON was on her way out door to leave, the resident returned to the front wearing gloves and headed out the door, stating he was walking to Des Moines or the law could take him to jail. The responding officer had remained in the parking lot and exited his car when he saw Resident #4 walking. After 15 minutes, staff and the police officer coaxed him back inside by reminding him how cold it was outside (35 degrees). The DON then permitted him to smoke outside in the courtyard after he promised he would go to bed and they would meet tomorrow. After he smoked outside, he went to his room after the DON coaxed him to come in from the cold and had no other outbursts or attempts to exit the facility. -4/9/2020 at 9:10 AM Resident #4 exited the building and attempted to leave the grounds. The social worker went with him and he kept	F 689		

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repeating, "I'm not going back in there, I can't go back in there." After numerous attempts by the nurse and CNAs to persuade him to come into the facility, he attempted to leave the grounds. The facility notified the police department. An officer arrived, talked with the resident and redirected him back into the building.

-4/11/2020 at 4:04 PM: Resident #4 made attempts to leave several times this shift. He demanded staff provide him cigarettes or he will leave. A CNA reached out to the DON and on-call nurse via phone to see if they could either come in and provide 1-1 supervision or make suggestions on how to deal with the situation. The DON told staff no management staff would come to the facility. Staff took Resident #4 outside to smoke two times on that shift in an attempt to calm the resident.

-4/12/2020 8:47 AM: Resident #4 exited the facility through the front door. A nurse and other staff followed him outside, but he refused to come back into facility. He stated he is walking to Des Moines, and wanted the facility to call the police because he wanted to go to jail. The on call nurse called the police. An officer arrived and escorted Resident #4 back inside the building.

-4/18/2020 at 11:24: Resident #4 found with his body hanging out the window as he smoked a cigarette. Staff immediately asked him to give the nurse his cigarette and he became very annoyed and refused. He stated, "Let me finish it or I am leaving." A staff member stayed with him while the nurse went back to his room to search for lighter or cigarette, but was unsuccessful. Resident #4 finally threw his cigarette on the ground outside.

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F 689	Continued From page 23 -4/21/2020 at 3:16 PM: At approximately 2:30 pm on 4/21/2020 the Administrator heard the front door alarm sound and responded. Upon going outside, she saw the charge nurse in parking lot asking Resident #4 to return to the building. The resident continued to walk across the street turning to go South at the corner. The Administrator followed him, with resident ignoring all requests to return. Resident continued to repeat he was going to get himself a lighter. Resident turned west at first cross section and continued west with the Administrator beside him. Resident stated he would return to the center as soon as he found a lighter. Resident asked people in their yards and while walking along street for a lighter. One man came to curb despite the Administrator's attempts to intervene and tell the man the resident could not have a lighter. Resident #4 pulled a pack of cigarettes from his pocket and the man lit his cigarette. The resident turned and began walking back to the facility without further prompting. Resident had walked approximately 4 blocks away total. When asked where he got the pack of cigarettes, he refused to answer, but proceeded to engage in conversation about the nice weather. Once at the facility, he sat down outside on front bench and finished his second cigarette. The Administrator offered to take him to the court yard but he refused. The Administrator asked a CNA to sit with him for supervision. At 3:31 pm, the resident had still refused to come inside. The Administrator called Operations Director and recommended 1:1 staff for a while and if necessary, call law enforcement. -4/21/2020 at 6:30 PM Resident #4 went out front door and a nurse went outside with him. He stated because he was supervised he could go	F 689		

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anywhere he wanted and kept walking down the street. The nurse offered to take him to the courtyard and he declined, so another nurse had to retrieve him with her vehicle.

-4/22/2020 7:05 PM: Resident #4 exited the facility and refused redirection by staff. He asked to speak to a supervisor, so staff called the DON. The DON instructed staff to give him a cigarette and they complied.

-4/23/2020 9:36 AM: At 9:20 AM Staff D Licensed Practical Nurse (LPN) was off-duty and driving back from Des Moines. She noticed Resident #4 walking south bound on the main street in town by the convenience store and a pizza restaurant. Staff D approached him and identified herself and he was pleasant and cooperative, with cup of coffee and cigarette in his hand. When asked what he was doing he reported he bought a good cup of coffee and some cigarettes. Staff D told him he needed to come with her back to the facility but he requested to walk. Staff D called the facility immediately. Staff P CNA and Staff Q CNA drove to the area in their car, picked up the resident and drove back to the facility. Resident went to the court yard and yelled, "It's too beautiful out to be inside!" The facility placed Resident #4 on 1-1 supervision.

-4/23/2020 12:37 PM: Staff notified Resident #4's sister he had removed his wander guard.

Review of Resident #4's clinical record revealed the facility's 15 minute checks documents. The document was used for staff to document where he was every 15 minutes. There was a column with the time; starting at 12:00 AM laid out in 15 minute intervals until 11:45 PM. To the right of

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that column was space where staff could document where he was. Continued to the right, staff could initial. Further review revealed a 15 minute document dated 4/23/2020 with Resident #4's name and room number written at the top. The column that documented where he was from 7:15 AM to 9:15 AM on 4/23/2020 was left blank. Staff V documented Resident #4 was in his bedroom at 7:00 AM, there was no documentation until 9:30 AM when Staff Z CNA documented he was in the court yard. Review of the last 3 months of documentation revealed 35 days had missing documentation related to Resident #4's whereabouts.

Review of the resident's clinical record revealed it did not contain an incident report related to the 4/23/20 elopement or any documentation of a head-to-toe assessment of the resident's condition after he returned to the building on that date.

Observation on 8/25/2020 at 11:32 AM revealed a key pad at the front entrance which required staff and visitors to enter a code in order to exit the building. There was a note next to the key pad that directed after entering the 4 digit code, wait for the LED light to turn green before exiting. The surveyor opened the door without entering a code and an alarm sounded. The Dietary Supervisor was at the main entrance at time and she was asked what would happen if someone with a wander guard opened the door without putting in the code. She stated a very annoying alarm will sound at the front nurse's station.

Observation on 8/25/2020 at 11:36 AM revealed Resident #4 was in his room alone and with no staff present on the hall. At 12:18 PM, a staff

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member accompanied Resident #4 at the nurse's station as the nurse gave him his cigarettes. Observation at 1:52 PM revealed Resident #4 lay in bed. He appeared to be asleep. No staff were on the hall or at the nurse's station.

An observation on 9/1/2020 at 9:35 AM revealed Resident #4 in bed with his eyes closed and no staff members in the hall or at the front nurse's station. The Daily Schedule at the nurse's station listed a staff member as his 1-1 staff for the 6:00 AM -2:00 PM shift. On 9/1/2020 at 9:50 AM revealed an alarm sounded when the surveyor opened the front entrance door without putting in the code. At 11:58 AM, the resident sat in his recliner in his room. Observation revealed no staff members at the front nurse's station, the 100 (where Resident #4 resided), or 200 halls.

Observation on 9/3/2020 at 12:54 PM revealed Resident #4 in the court yard smoking a cigarette. A staff person sat in the dining room by the court yard door looking at his cell phone.

During an interview on 8/25/2020 at 2:53 PM the DON stated he must be within sight of the staff and when in bed, someone needed to check on him and keep an eye on the hall. She added that certain staff can "set him off," which was why it was changed to in line of sight supervision. When asked what staff do when he smokes in the court yard, she responded if he is out there alone, staff can watch him from the window, although he will let some staff go outside with him. If there's another resident smoking, then a staff member must go out with him to the court yard.

In a subsequent interview on 9/24/2020 at 12:30 PM, the DON was asked what Resident #4's

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F 689	Continued From page 27 supervision level was prior to his elopement. She responded the resident was independent in the facility without every 15 minute checks or 1-1 supervision. She stated after the elopement, they put him on 1-1 within line of sight because he had behaviors when he had 1-1 staff. The DON was then asked why staff had not documented the 15 minute checks on the form around the time Resident #4 had left the building on 4/23/2020; she stated, "Well, now I am confused." She asked to review his progress notes. Once the notes were reviewed she stated he was on 15 minute checks and remembered this because he had more than one incident so they did the 1-1. He kept going out the front door because he was mad, but wasn't going anywhere. Staff knew he was going out there, went out with him and stood at the main entrance area. She stated he would take off because he was mad about something and storm out the front door. She stated that was when the 15 minute checks began, and staff were to complete the 15 minutes check forms every shift. After he eloped to get coffee was when the 1-1 truly started. She offered that Resident #4 did have a wander guard, but would remove it, but currently does not have a wander guard on because he has staff with him. The DON was asked when the key pad was installed, she stated she does not remember because maintenance did that. When asked if she felt like they had enough staff to cover Resident #4's supervision every shift, every day; she stated they had a couple of days that were a struggle so everyone worked as a team to keep an eye on him with no designated staff. During a staff interview on 8/28/2020 at 10:23 AM Staff W Provisional Administrator was asked to describe Resident #4's supervision level prior to	F 689		

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his elopement to Casey's. She stated she believed he was just utilizing the wander guard and he would take it off, put in the top draw, and frequently try to leave. She stated prior his elopement, he required the same supervision as others with wander guards on and did not have 1-1 staff. She said she needed to look at his 15 minutes sheets to see when those were started. She offered that when Resident #4 was admitted to the facility he was on general supervision. She thought the first time he removed his wander guard was when staff found him by the convenience store. The Provisional Administrator stated Resident #4's could not make appropriate decisions on his own. At times he understands what is said, at other times things do not register and he does not answer appropriately, it depends on the day.

During a staff interview on 8/25/2020 at 3:50 PM Staff W Provisional Administrator was asked what type of supervision Resident #4 currently required and she answered 1-1 staff supervision, but changed her answer to eyes on his door. She stated he has an assigned staff member every shift for this. When asked if it was strictly nursing staff that sat with him, she stated it could be non-nursing staff since they were not providing direct care.

During a staff interview on 8/25/2020 at 1:35 PM Staff D was asked to discuss the event that took place on 4/23/2020. She stated she had drove down the street and saw Resident #4 walking on the sidewalk. She stopped in the middle of the road and asked what he was doing, and he said he got a good cup of coffee and cigarettes. She asked him where he was going, he told her he was going home to the facility. Staff D stated she

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F 689	Continued From page 29 called the facility and less than 5 minutes later 2 CNAs came to get him. She stated he did not want to get in her car because it was too nice and he said wanted to walk. She added it was about 9:20 AM and a summery/spring like day; not hot, sunny, not raining. Staff D reported he wore a winter coat shoes, pants, and a cap. Resident #4 told her he walked right out the front door. Staff D believed he was to have a wander guard but he removed it a lot, so they applied the wander guard to his winter coat. Staff D described the alarm system at the front entrance. People could push a door bell type button which bypassed the alarm when the door opened. If someone opened the door without pushing the button or wore a wander guard, the alarm would sound. Staff D reported the facility installed a key pad at the front entrance and if someone exits without putting in the code, it would alarm behind the front nurse's station. Staff D stated Resident #4 had left or tried to leave the building multiple times with or without staff. Staff D said the resident should have 1-1 supervision at all times. During a staff interview on 8/26/2020 at 11:28 AM, Staff R LPN reported Resident #4 required 15 minute checks prior to his elopement, but had staff 1-1 with him currently. During a staff interview on 8/26/2020 at 1:48 PM Staff P CNA stated prior to going to the convenience store, he had issues with leaving. She stated she had been a bath aide on 4/23/20 and remembered he required checks because he was at risk for elopement; she had last seen the resident prior to breakfast at about 7:30 am that day. Staff P reported now they barely have a 1-1 for him, although they try to tell someone they have to do it or try to grab a dietary,	F 689		

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F 689	Continued From page 30 housekeeping, or laundry staff to help. She added she did not think non-nursing staff should provide the 1-1 supervision because of his aggressive behavior history and the other departments have not been educated so they know what to do. During a staff interview on 8/26/2020 2:22 PM, Staff F LPN stated she had worked the day Resident #4 had eloped to the convenience store. She said he now required 1-1 staff supervision, but they did not have a staff person to do it. She reported that this happened frequently and she had mentioned it to the ADON, who said they were working on it. Staff F stated there should be eyes on him at all times, although originally they had to be right outside of his door but they had backed off because he would have negative behaviors. Staff F stated staff do not go out with him to smoke, but does have to get cigarettes and lighters from the nurse's station. When asked how the front entrance was alarmed, she stated if a resident wore a wander guard and walked by the front entrance it would alarm. She stated everyone knew he took his off and then he would push the button to get out. She said they wanted to put a wander guard on his ankle, but he had swelling and the facility "was denied getting bariatric bands" so they could apply a bigger bracelet to his ankle. When asked how staff complete wander guard checks, she stated the facility has a little box with a button on it. If staff pushed the button and it was green, it meant the band is functioning, but if it shows red the band is expired. Staff F also offered that not all residents that had wander guards did not have it listed on their MAR like they should. She added the front entrance now has a key pad to exit the facility and if the door is opened without a code, it would sound alarm at front nurse's station.	F 689		

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During a staff interview on 8/26/2020 at 12:49 PM Staff Q was asked to describe Resident #4, she stated he was a nice guy that liked to go on adventures. Staff Q was asked if she knew what Resident #4's supervision level was at that time, and she stated his door was to always be open and he had a 1-1 staff at the time.

During a staff interview on 8/26/2020 at 3:11 PM Staff T CNA over stated she had worked 1-1 on the overnight shift for Resident #4. She stated Resident #4 would get up at 5-5:30 AM to smoke and she went outside with him and then he would go back to bed. Staff T stated when he wanted to leave, staff would get the DON and she would usually talk him down. Now he needed a 1:1 and staff sat kitty corner from his room as his moods depended on where they sat. Staff T reported after he started to leave, he was placed on 1-1 supervision. She added if they are short staff they are unable to provide that supervision because they were helping other residents, which left nobody to watch his hall. Staff T stated they used to have staff to cover his 1-1, but they don't now because some staff "no call, no show" or were off ill. She said they do their best to keep their eyes on him, but now with all the residents in their rooms, it is hard to see what is going on.

During a staff interview on 8/28/2020 at 2:54 PM Staff X CNA said staff were to follow him and keep him within eye sight and he has 1-1 staff supervision. She stated they were staffing the 1-1 for Resident #4 during all 3 shifts. When asked if this was always possible, she stated there were times when the 1-1 can't make it or called in, so they were asked to pull together and keep an eye on him. She added that when they had to try

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make it work she would make sure she did 15 minutes checks and document it on the paperwork at the front nurse's station.

During a staff interview on 9/8/2020 at 12:29 PM Staff Y Cook, stated he did 1-1 with Resident #4. When asked if he had any training prior to doing 1-1 cares, he stated he did not have training. He stated he was told to keep him within line of sight; he could give him space but needed to see him. Staff Y stated that was his mainly because he can't do lifting, so he has been assigned to help with the 1-1 supervision. When asked how he got along with Resident #4 he stated they get along pretty good and will talk to him about random stuff. When asked what Resident #4's cognitive states was, he stated he thinks is knows what is going on but when he would talk with him all he says is uh huh, uh huh.

During a follow up staff interview on 9/10/2020 at 9:21 AM Staff W stated Resident #4 took his wander guard off and waited until the nurse was down the hall passing medications so he could exit the facility. She stated he was able to push in the code to leave the building. She thought he had likely watched staff entered the code until he memorized it, although he was not completely coherent and could not always not track well. Sometimes his answers were appropriate and other times not, and his cognition came and went depending on the day. When asked to describe what happened on 4/23/2020, Staff W stated he went to a nearby convenience store to get a good cup of coffee and an off-duty nurse spotted him as he walked back to the facility. She stated the facility implemented 1-1 supervision with him at that time. Staff W stated Resident #4 came to her office and stated if I could walk I would not do

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F 689	Continued From page 33 dumb stuff, I just want to walk. After Resident #4 was found walking back from Casey's they made him 1-1. When asked what this meant, she stated staff were to be in close proximity, outside of his room. During her last 3 weeks at the facility he started to get agitated because he felt they were on top of him. So they started to do keep him within sight so staff had to be able to see him once he was outside of his room. When asked when the push button at the front entrance was changed over to a key pad, she stated she did not remember. She stated they had an elopement prior to this so not sure when they did that key pad. She commented the day he requested walks, he knew what he talking about. Then later he wanted to mow and was not tracking with her and the conversations they were having. She stated he does know how to work people too. She stated for example, when they would complete his BIMs he would not do well for one staff, so they could get another staff member and he would score higher. During a staff interview on 9/24/2020 at 5:00 PM the Maintenance Director was asked when the push button to exit the facility was removed and the key pad was installed. He stated July of 2020 and the wander guard alarm was installed at the same time. When asked when the door alarms, he stated when you do not enter the code and walk out and when there is a wander guard present. The facility was notified of the Immediate Jeopardy situation on 8/27/20. The facility abated the IJ on 8/28/20, and the Scope and Severity of the IJ was lowered to an "E" level at that time. The facility abated the IJ on 8/28/20 by taking the following actions:	F 689		

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a. Completed an updated Elopement Assessment and BIMS test for Resident #4.
Resident #4.

b. Revised the 15 minute check sheet and the Supervision Protocol.

c. Created a new audit tool and will initiate audits for 12 weeks to be reviewed by Quality Assurance Committee.

According to the quarterly Minimum Data Set (MDS) with a reference date of 9/12/2019, Resident #12 had a Brief Interview of Mental Status (BIMS) score of 0, indicating severe cognitive impairment. The MDS documented Resident #12 had periods of fluctuating difficulty focusing his attention and had disorganized thinking. The MDS recorded he exhibited physical and verbal behavioral symptoms directed towards others 1 to 3 days during the 7 day review period. The MDS indicated he required supervision with setup help for bed mobility, transfers, walking within the facility and was independent while walking in his room. The following diagnoses were listed: Alzheimer's disease, non-Alzheimer's dementia and heart disease.

Review of Resident #12's care plan revealed the following focus area: Adverse effects of inappropriate grabbing/touching with an initiation date of 09/25/2019 and a revision date of 9/25/2019.

-Begin 15 minute checks for at least 24 hours, date initiated: 12/04/2019
-Ensure Resident #13 remains out of his room and maintains a safe distance away from this

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F 689	Continued From page 35 resident, date initiated: 09/21/2019 -Move from memory care unit to 400 hall and continue 15 minute checks for the day. date initiated: 12/05/2019, revised on: 02/03/2020 -Place resident on 1-1 if he has contact with any female resident and report to the Director of Nursing and Administrator, date initiated: 02/05/2020 -Redirect him from any contact with Resident #13, date initiated: 12/04/2019 -Redirect him if he is observed in close range of a female resident, date initiated: 12/04/2019 Review of Resident #12's clinical record revealed the following progress notes: -7/26/2019 at 8:02 AM: Faxed primary care physician regarding resident's increased behaviors: agitation, exit seeking, inappropriate comments to female staff, attempting to hit staff, non-compliance with the use of his walker. Staff will continue to monitor. -8/16/2019 at 9:30 AM: A Certified Nursing Assistant (CAN) reported while assisting resident in the memory care unit lobby, she witnessed a female staff member come up to resident and kiss him on the lips. The staff member and resident were separated. -9/21/2019 at 2:56 PM: The nurse responded to the memory care unit and a CNA reported Resident #12 was in his room with a female resident sitting on his bed and he had his left hand in her pants. He immediately removed his hand when the CNA entered his room. Residents were separated and female resident was directed to her room. -9/23/2019 at 9:15 AM: Resident #12 slept in a recliner in the memory care lobby. A female resident entered the lobby and he started to make	F 689		

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F 689	Continued From page 36 inappropriate sexual comments. Staff attempted redirection and Resident #12 then became agitated at staff and yelled profanities. At 6:30 AM Resident #12 had a baby doll in his hands and began to make inappropriate motions with the doll. Staff again redirected, and again the resident became inappropriate and yelled at staff. After breakfast he sat in the lobby. After caring for another resident, staff entered the lobby and saw the resident try to hold a female resident's hand. Staff redirected him before contact occurred and he became agitated and yelled at staff and talking about leaving. At this time resident wandering up and down hallway attempting to enter other resident's rooms. Staff successfully redirected him and staff will continue to monitor. -11/18/2019 at 12:38 PM: Resident #12 noted to have increased sexual behaviors toward staff and verbal aggression toward a female resident this morning. Staff attempted to redirect several times without success, but then were able to redirect him to his room with no farther behaviors noted. -12/4/2019 5:52 AM: CAN reported at 5:50 AM that Resident #12 was outside his room door with a female resident with his hand inside her brief. The CNA was coming out of another residents room and heard "no, no." She approached them and separated them immediately, and Resident #12 hit the CNA as she intervened. -12/4/2019 10:10 AM: Follow up inappropriate behaviors with a female resident. Resident #12 on every 15 minute checks and noted to be very agitated this morning after the incident by exit seeking, pulling on doors, yelling at staff when ambulating to room, using profanity and racial slurs. When the nurse entered his room to give him his medication he was agitated and cursing. Resident #12 then made several sexually inappropriate comments to the nurse and also	F 689		

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initially refused to take his medications. The resident finally took his medication, went to breakfast and then returned to his room.
-12/5/2019 11:56 AM: the social worker spoke with Resident #12's family about a move from the unit and they were fine with it.

When asked, the facility was not requested, the facility were not able to provide any incident reports related to resident to resident incidences that involved Resident #12

According to a quarterly MDS with a reference date of 11/14/2019 indicated Resident #13 was severely impaired when making daily decisions. The MDS indicated she displayed physical and verbal behavioral symptoms 1 to 3 days during the 7 day review period. Resident #13 required set up help for bed mobility, supervision for transfers and walking on the unit, and remained independent with walking in her room. The MDS listed the following diagnoses for Resident #13: Alzheimer's disease, non-Alzheimer's dementia, depression, and cerebral aneurysm.

The care plan documented Resident #13 had an Activities of Daily Living (ADL) self-care performance deficit related to confusion and dementia; initiation date of 8/4/2020, revision date of 8/26/2020. The care plan also documented she had impaired cognitive function/dementia or impaired thought processes related to dementia; initiation date of 9/24/2018 with a revision date of 2/7/2019.

Resident #13's care plan revealed the following focus area: Adverse effects of inappropriate grabbing/touching; with an initiation date of 9/25/2019. The care plan directed staff:

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-Staff were directed to complete 15 minute checks for at least 24 hours; initiation date of 12/04/2019.
-Staff were encouraged to redirect Resident #13 if they found her out of her room with no pants or slacks; initiation date of 12/4/2019.
-Staff to provide her with activities to assist her with engaging in appropriate behaviors; initiation date of 9/25/2019.

Review of Resident #13's clinical record revealed the following progress notes:

-9/21/2019 at 11:02 AM: a CNA reported Resident #13 was very upset after being separated from another resident. When staff assisted her to her room, she slammed her door and it hit the left side of her head from her forehead and past her left eye. Skin areas intact but monitoring for bruising.
-9/21/2019 at 2:45 PM: CNA reported Resident #13 was in Resident #12's room sitting on the bed and Resident #12 had his left hand under her shirt, under the pants. The CNA stated that the resident immediately removed his hand as the CNA entered the room. The residents were separated, and 2 staff assisted Resident #13 with guided ambulation. The resident displayed agitation and began hitting at staff. Resident was redirected to her room. The doctor, family, ADON and Administrator were notified of incident.
-9/22/2019 at 2:50 PM: Resident #13 continued to be on detailed location charting and separated from Resident #12. She accepted meds without issue and spent most of the shift in the day room near staff. Resident #13 denied pain or discomfort, but was tired throughout the shift and

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rested frequently.
-12/4/2019 5:58 AM: At 5:50 am, CNA reported Resident #13 was outside Resident #12's room and the CNA heard, "No, no." Resident #12 had his hand inside her brief and the CAN intervened and separated the residents immediately.
-12/4/2019 6:05 AM: Resident #13 ambulating per usual and up twice during the night to remove her brief and pajama. Staff dressed the resident in her brief and her robe. Staff noted no redness or bruises in the resident's perineal area during assessment,
-12/4/2019 10:12 AM: Resident #13 remained on 15 minute checks. The resident sat in the memory care lounge wearing a house coat, t shirt and brief this morning. Staff attempted to assist the resident with dressing and the resident became very agitated, yelling and attempting to strike staff. No injury or bruising noted throughout body, but the resident refused to allow staff to conduct a full head to toe assessment to be completed.

When asked, the facility was not able to provide any incident reports related to resident to resident incidences that involved Resident #13

Review of the facility's investigation of the incident revealed the following summary of incident:

On 12/4/2019 at approximately 5:30 AM, Resident #13 walked out of her room independently wearing a robe, t-shirt, and an adult brief. She had previously refused 2 twice when staff attempted to put on her pants and then when they were on she kept taking them off. A CNA heard Resident #13 say, "No, don't do that" and walked out of another resident's room. She

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found Resident #12 in the hallway with Resident #13 with his hand in her brief.

The investigation had the following witness statements:

-Staff CC CNA stated she was coming out of room 303 when she heard NO. Resident #12 and #13 were outside of room 309, Resident #12 had his right hand in Resident #13's brief. She told him no and was pushing his hand away. Resident #12 yelled at her, kept his hand placed in her brief and pushed her. Staff CC ran down the hall and stated get your hands out of her pants; Resident #12 hit Staff CC then proceeded to his room. Resident #13 was combative with redirection and started hitting staff. Staff CC stated Resident #13 wore only a robe and no pants because she had removed them twice and refused to keep her robe tied. Staff CC had left Resident #13 in her room to assist another resident and she reported the incident to the nurse.

-Staff R CNA stated around 5:45 AM she was putting her lunch in the unit fridge when she saw Resident #13 in the hallway wearing a shirt, an adult brief and a housecoat that was open in front. Staff CC was standing by Resident #13 and Resident #12 was already in his room. Staff CC mentioned that just prior to her getting there, Resident #12 had his hand down Resident #13's brief. Staff CC had told Staff R that Resident #13 had taken her pants off two times prior to coming out of her room.

During a staff interview on 8/26/2020 at 12:49 PM Staff AA Certified Medication Aide (CMA) stated she worked on the unit a lot. When asked if she felt there was sufficient staff on the unit to ensure

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F 689	Continued From page 41 everyone is safe and their work is completed, she stated they always have 2 CNAs on during the day and evening, but even with 2 staff there are still issues with residents because they are tough to handle and need more eyes on them. During a staff interview on 9/2/2020 at 9:40 AM Staff CC CNA stated she worked the morning of the incident between Resident #12 and #13. She stated that was the first and only time working there. She stated there were a lot of residents on the hall during her shift. When asked how far Resident #12 had his hand down Resident #13's brief, she stated his hand was down to about wrist level. She stated she heard Resident #13 say "no, no" and went down to separate them. Resident #12 got mad and Resident #13 pulled her robe together; she only had a robe and brief on if she remembers correctly because she kept undressing herself. Staff CC stated those resident were kept separated and she kept an eye on Resident #12 to make sure he did not approach her again. She informed the oncoming staff about the incident. Staff CC added she felt like Resident #12 knew he was doing. She stated when Resident #13 told him no, he became more aggressive and mumbled something but could not tell what he said. During a staff interview on 9/2 at 10:16 AM Staff R CNA was asked about the incident that took place between Resident #12 and #13, stated which time. When asked about the incident that took place on 12/4/2019, she stated she worked on the memory care unit that day. She came in to work about 5:30 AM and was putting her stuff away. She stated Staff CC told her Resident #12 had his hands down Resident #13's brief. Staff R told Staff CC to stay there and she would go get	F 689		

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F 689	Continued From page 42 the nurse on duty, Staff T LPN. After that, Staff R kept the two residents separated; Resident #13 was usually up front in the lobby and Resident #12 stayed in his room. Then they moved Resident #13 closer to the lobby on the unit. Staff R stated the men on the unit were at the end of the hall and the ladies are up front. Staff R stated incidents like his had happened with Resident #12 prior to this incident, he was just ornery. When asked what other incidences she stated he tried to hold hands and be inappropriate with staff and residents, but nothing physical that she remembers. She said staffing is not the greatest, it is hard. She noted they always had two staff back there except on overnights. When asked if she felt like there were enough staff to keep everyone safe and get tasks done, she stated there is not enough staff to get stuff done and keep people safe. She stated since COVID started they have to feed residents in their rooms, it is hard to do that and keep their eyes on residents that wander. During a staff interview on 9/2/2020 at 11:21 AM Staff DD LPN briefly remembered what happened that day. She reported Resident #13 appeared fine and ok and did not remember appear to remember if anything had happened, but she was mad while the nurse took her vital signs. Staff DD stated it was common behavior for her to gravitate toward men and staff were encouraged to redirect the behavior. She stated Resident #12 was more inappropriate towards staff, rarely with residents. She remembered him only being verbally aggressive towards staff but does not remember him being that way with female residents. When asked how he acted around Resident #13 she stated he was more sexually inappropriate and would make hand gestures or	F 689		

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F 689	Continued From page 43 sexual gestures, and staff would redirect the behavior. When asked if she felt staff were able to keep everyone save on the memory care use, she stated she felt like they did what they could. She added it was hard to keep everyone separated. During a staff interview on 9/2/2020 at 11:36 AM Staff W CNA stated she worked on the unit during her scheduled shifts. When asked about Resident #12 she stated he had had some sexual behaviors with another resident. She stated they were to keep them apart. Staff W stated they eventually moved him off the unit. Staff W reported on 9/21/2019, Resident #13 was the female staff found Resident #12's bed and she found them while doing rounds. She saw Resident #13 sitting on the edge of his bed. She went in to separate them and Resident #13 became upset, as Resident #12 kept saying I am sorry, I knew better. Staff W would inform them they could not do that, that is was not ok. When asked what type of inappropriate behaviors Resident #12 displayed, she stated he would put his hands down Resident #13 pants, would touch her breasts and she would touch him inappropriately too. Staff W stated they kept Resident #13 down the hall and Resident #12 in the lobby area. She stated they used to be across the hall from each other, but had been moved and now they had a whole hallway between them and it seemed to help, but she would still walk down the hall where the males were at and would redirect her back to the lobby area. When asked how staffing was on the unit, she stated there were some days there is not enough staff to keep them safe, especially those at risk for falling. Then there were other days when there were no behaviors, everything was good.	F 689		

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F 689	Continued From page 44 During a staff interview on 9/2/2020, Staff T LPN was asked about any incidences between Resident #12 and #13 she had witnessed. She stated staff had raised concerns before because their rooms had been closer together and they both would wander; she would go in to men's rooms because she does not understand. She was the more cognitively impaired of the two. She added she stated they found her going toward or in his room. He had put his hands on her breasts and was very sexual with her but she was not sexual in return. She stated before COVID residents ate in the dining room, but now they eat in their rooms so it is hard to watch everyone on the unit. Staff T stated she thinks they should have done more than just watching the two. She said the staff do what they can but the residents are too much for what staff they have to properly watch them and take care of them. During a staff interview on 9/3/2020 at 4:21 PM Staff BB Licensed Practical Nurse (LPN) stated she worked on the unit. When asked to describe Resident #12, she stated he would walk around a lot, had a catheter, behavior issues frequently. When asked what kind of behaviors she stated he would get agitated with staff and other residents. She stated staff would do a lot of 1-1 with him to make sure he was never alone. When asked about the incident that took place on 12/4/2019, she stated she does not remember it vividly, but did remember the residents were separated when she arrived to the room. She stated the incident was reported to her from another staff member and when she got there they were already separated. Staff BB stated both residents wandered on the unit, and they staff with 2 CNAs to keep them out of each other's	F 689		

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F 689	Continued From page 45 rooms. Both residents required lot of redirection. During a staff interview on 9/22/2020 at 6:11 PM Staff EE CMA/CNA was asked about staffing and she stated she does not feel like there are enough staff back there because of residents wandered and had behaviors. During a staff interview on 9/24/2020 at 12:30 PM the Director of Nursing (DON) was asked if she remembered the incident before Resident #12 and #13 on 12/4/2019. She stated it was her first or second day as DON but did remember what happened. She stated she spoke with Resident #12 after the incident and he told her (Resident #13) was there for the taking. She stated she did not know him before the incident and after they moved him out of the unit he never had issues again. So, she can't say if it was common behavior or not for him to have inappropriate actions with other residents. When asked if this was normal behavior for Resident #13, the DON stated she did not believe that she was out looking for those things to happen, they just did. She stated Resident #13 was not one to instigate it, it just happened. The DON asked what staff were to do to prevent these things, she stated staff were to redirect the residents and encourage Resident #13 to wear clothes. She stated Resident #13's behavior of not wearing clothes has subsided. The DON stated she felt they had adequate staff on the memory care unit.	F 689		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting	F 868		

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at a minimum of:
(i) The director of nursing services;
(ii) The Medical Director or his/her designee;
(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role;

§483.75(g)(2) The quality assessment and assurance committee must:
(i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary.
This REQUIREMENT is not met as evidenced by:
Based on facility record review and staff interview, the facility failed to ensure they had an effective quality assurance program in place. The facility reported a census of 56 residents.

Findings include:

Review of the survey activity reports posted in the facility revealed the following deficiencies identified during the survey activities listed below:

-residents were free of accidents and hazards and provided adequate supervision for residents resulting in elopements cited during the current investigation, during the investigations ending 3/25/2020 and 6/9/2020 and during an annual survey and investigation ending on 6/20/2019

-residents care plans were not updated accordingly during the current investigation, during an annual survey and investigation ending on 6/20/2019

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F 868	Continued From page 47 -no effective quality assurance program in place during the current investigation and during an annual survey and investigation ending on 6/20/19. During an email correspondent on 9/25/2020 at 2:34 PM the Regional Manager was asked to provide Quality Assurance action plans and projects since April. He responded with audits in all the months but no official action plans until August and September. He also included blank audits that are still in process from prior surveys.	F 868		