STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165590	A. BUILDING _____ B. WING _____	C 01/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENCE NURSING HOME	402 2ND AVENUE CLARENCE, IA 52216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS OK V TAG Correction Date: 2/8/2021 The following deficiency relates to the investigation of the following Facility Self-Reported Incidents #95163 and #95180 conducted 1/14/21 through 1/25/21. Both Incidents were identified to be substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000		
F 689 SS=G	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 observations, record review, family and staff interviews, the facility failed to identify the resident's window as a potential exit with which the resident eloped through for one of five residents reviewed for supervision (Resident #1). The facility reported a census of 41 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) Admission Assessment completed 12/25/21 documented the following diagnoses: traumatic brain dysfunction, non-traumatic subarachnoid hemorrhage, atrial fibrillation (an abnormal heart	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 2/8/2021

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 rhythm) and orthostatic hypotension (a decrease in blood pressure within three minutes of standing). It also identified the resident as cognitively intact with a Brief Interview for Mental Status) score of 12 out of 15, required limited staff assistance with walking and personal hygiene. The Care Plan with the target goal date of 1/6/21 identified the resident with the problem of being at risk for falling as he is constantly walking, has exit seeking behaviors without safety awareness (date initiated 12/18/20) Interventions included: a. Arrange for male staff to accompany, 1:1 with him as less suspicious of men. Topics of interest: farming and golfing. b. He enjoys a cup of coffee with a snack. He likes to look at the phone book. c. Be alert to him wearing his coat and hat in the facility, as a cue he intends to leave. Attempt to engage with visiting with wife, with activity board, sorting nuts and bolts, offer a cup of coffee and snack. d. If he becomes fatigued or dizzy, allow him to rest. e. Keep his room door open (even with quarantine) so he has supervision of his activities so he is safe f. Prompt him to change positions slowly as he can become dizzy with initial standing g. Redirect him to his room for less stimulation when he is angry. He often tires himself and needs to nap to change his mood. h. Secure Care Wander Bracelet applied to ankle to alert staff to presence at exit doors. Join to assist with redirection from leaving facility (date initiated 1/8/21).	F 689		

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F 689	Continued From page 2 A review of the Incident Report dated 1/12/21 at 5:00 a.m. had documentation of the following: The resident had been observed laying outside in the parking lot, groaning and laying on his left side, alert and responsive but unable to state what he was doing or what happened. Immediate action taken: Lifted into a wheelchair with the assistance of three staff members and returned to the facility and his room with transfer to bed Interventions: Comfort care for right hip fracture at the facility. Family decision for Hospice care and pain management Mental status: Oriented to person, situation and place Notes: Small irregular lacerations to back of the head. Previous laceration opened at back of the head. Right elbow with 2 cm (centimeters) irregular shaped laceration and right wrist with 2.5 cm "C" shaped skin tear. Lacerations cleansed and dressings applied for comfort. Complained of right hip and thigh pain, rubbing his upper thigh area and demonstrated area of pain. Right leg is shorter than the left leg and foot rolled outward. The resident complained of pain when he moved his right leg. Injury type: Right trochanter fracture (hip). Other info: Last visual check at 4:30 a.m. sitting on his bed. In response to hearing a voice calling out, found his room door closed and over-the-bed table in front of door. Upon entering the room, noted window open and resident not present in his room at 4:50 a.m. He had removed the screen of the window to exit through the window. Temperature 26 degrees outdoors. A review of radiology report dated 1/12/21 of the right hip revealed an acute lower femoral neck/intertrochanteric fracture is noted with	F 689		

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F 689	Continued From page 3 increased angulation deformity. A review of the nurse's notes revealed the following: a. On 12/20/20 at 10:21 p.m., Needs reminding to ask for assistance when up. Ambulated to front lobby from room without assistance. Joined and assisted back to room. "I'm just going to walk out of here sometime and go home." b. On 1/2/21 at 3:31 p.m., Resident wearing coat and stocking hat wandering about the nursing facility, stated he is tired of sitting around and wants to leave. c. On 1/7/21 at 4:08 a.m., Resident very agitated and determined to go home this shift. Going to doorways and attempting to go out. Had hat and coat on and insisted on leaving. d. On 1/8/21 at 10:02 a.m., Exited facility, staff joined and accompanied back to the facility. Secure Care Wander Bracelet (anklet) applied to help with exit seeking behavior. e. On 1/8/21 at 5:00 p.m., Wearing his coat & cap with and heading to the north exit door stating needed to "go get his golf cart to service it". f. On 1/8/21 at 8:00 p.m., Attempted to exit front lobby door. Agitated and very hard to redirect back into building. Attempted to bite and did hit Certified Nurse Aide (CNA). Finally able to get resident back into the lobby. g. On 1/9/21 at 3:16 p.m., The resident exited the north door followed by staff to the parking lot. Staff able to convince him to return to the building with extensive prompting and cueing at 12:00 p.m. h. On 1/10/2021 at 9:30 a.m., Reportedly tore Secure Care band from leg overnight and up most of the night, drank 5 cups of coffee and had chips and dip, as well as verbalizing he was wanting to leave today. Around 8:10 a.m.,	F 689		

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F 689	Continued From page 4 resident attempted to leave, difficult to redirect, and staff able to return him back to his room & setup with a book to distract him. He returned to lobby & attempted to exit front door with CNAs diverting him, he then quickly turned & headed toward north door to exit. i. On 1/12/21 at 6:02 a.m. an entry stated at 4:15 a.m. the resident came to the front lobby with walker. Gait steady with ambulation. Asked if the doors were unlocked so he could go home. Informed the doors would not be unlocked until 6:00 a.m. At 4:30 a.m., Room check and observed him sitting on his bed. Content. At 4:50 a.m. Heard a faint calling out. On room check, room door closed and over bed table in front of door. Upon entering room, noted window open and resident not present. Observed him laying outside & in the parking lot. Staff joined the resident to support outside of facility. Alert and responsive but unable to state what he was doing or what happened. Groaning and laying on his left side. Lifted into a wheelchair with assist of 3 staff and returned to facility and his room. Small irregular lacerations to back of head. Previous laceration opened at back of head. Right elbow with 2 cm (centimeters) irregular shaped laceration and right wrist with a 2.5 cm "C" shaped skin tear. Lacerations cleansed and dressings applied for comfort. The resident complained of right hip and thigh pain, rubbing his upper thigh area with his right leg shorter than the left leg and right foot rolled outward. During an interview on 1/19/21 at 7:04 p.m., Staff A, Registered Nurse (RN) reported the resident did have a history of attempts to elope from the facility two or three times before this, and that he had been independent with ambulation using his walker and he did have a Wander Guard bracelet	F 689		

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F 689	Continued From page 5	F 689		

that he wore on his ankle. If he refused the interventions to distract him, we would try to engage him in another activity.

In an interview on 1/19/21 7:17 p.m., Staff B, RN reported the resident had a history of attempts to elope, he kept saying he wanted to go home. If the staff attempted interventions to redirect and he refused, the staff would need to attempt other interventions such as taking him to visit his wife, read the newspaper, offer snacks or walk with him to other parts of the facility, provide one on one to keep him engaged. She also reported Staff E, CNA checked on him 1/12/21 last at 4:30 a.m. At 4:50 a.m. they heard someone calling out, checked his room, found the window open and the screen popped out. They found his Secure Care band in the garbage can. They found him lying on the concrete on the parking lot. There was no snow on the parking lot, just the piles on the corners. He wore his jeans, flannel shirt, socks, and shoes without a coat, gloves or hat on. The temperature had probably been 22 degrees out. The staff assisted him to bed, Staff B did not notice any outward rotation of his legs. When she notified the family, they chose to keep him at the facility and not send him out to the hospital.

During an interview on 1/20/21 at 4:56 a.m., Staff C, CNA reported the resident had a history of attempts to elope from the facility prior to the date he eloped from his window. He did have a Wander Guard bracelet on his ankle which he had been able to remove. He had been independent with ambulation using a walker. The staff had to make rounds on the residents every 45 minutes during the night. Staff C and Staff E, CNA's had taken turns checking on the resident

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F 689	Continued From page 6 and Staff C saw him last at 3:30 a.m. When Staff E checked on him, she said his window was open and screen popped out. They found him on the concrete in the parking lot. She reported he did not have a coat or gloves on, laid on his left side and had some bleeding up on his arm and some on the back of his head. The staff assisted him to a wheelchair and back to his bed. She noticed the Wander Guard alarm bracelet in the garbage can. At that point, she left the room to tend to other residents. In an interview on 1/20/21 at 9:14 a.m., Staff D, CNA reported the resident had a history of attempt to elope from the facility and she had actually followed him as he eloped two or three times before he eloped from his window on 1/12/21. He had been able to walk outside to the dumpster using his wheeled walker. He had been care planned to be independent with wheeled walker. When they applied the Wander Guard bracelet on his ankle, he told her "that's not going to stop me from leaving" The staff had to check on him every 10 minutes, distract him, re-orient him or talk about his hobbies. He had dementia and refused interventions and when he did, Staff D reported would walk with the resident. During an interview on 1/20/21 9:57 a.m., Staff E, CNA reported the resident had a history of attempts to elope from the facility before the incident before he eloped from his window on 1/12/21, that he constantly tried to go outside, that he had been independent with his walker. The night shift staff had to check on him during the night every hour, and every 20 minutes if he had been awake. He always talked about wanting to go home or go to the store. He had a Wander Guard bracelet put on soon after he had	F 689		

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F 689	Continued From page 7 been admitted. On 1/12/21 she went to his room at 4:30 a.m. where she found him sitting on his bed. Later he came out to the hall to ask the staff to unlock the front door. They told him no and helped him back to bed. At 4:50 a.m. Staff B, RN and Staff E, CNA heard someone moaning. Staff E went to his room, found the bedside table behind the door and had a hard time opening it. She found the window open and the screen pushed out. She ran outside and found him lying on the concrete near the dumpsters. He did not have a coat on. It was 15 or 20 degrees outside that night. The staff helped him up into a wheelchair and back into his bed. She saw blood on his right forearm on the right side and a laceration from a previous head wound from a fall earlier that day. Upon returning him to the facility, she noticed the Wander Guard alarm did not sound when they came through the door and later found his Wander Guard bracelet in the trash can. The resident and family chose not to have him go to the hospital. In an interview on 1/20/21 10:25 a.m., Staff F, RN reported the resident had a history of attempts to elope from the facility prior to the incident on 1/12/21 when he climbed outside his window. The week before that fall, the attempts were frequent, he would keep trying to leave and put on his coat and hat when he did. A Secure Care bracelet had been placed on his ankle in early January 2021. He had been care planned to be independent with ambulation using his walker. In an interview on 1/21/21 12:10 p.m., the Social Worker reported the resident's family chose to keep him at the facility as his wife also resided there and they wanted to keep them together.	F 689		

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F 689	Continued From page 8 During an interview on 1/21/21 12:34 p.m., the Director of Nursing (DON) reported when a Secure Care bracelet is applied on a resident, all of the exit doors are alarmed and will all trigger when the resident goes out. When this resident had first admitted to the facility, his family reported he did not have exit seeking behaviors prior to this. After January 1st, his behavior changed drastically. After the incident with his elopement from his window, the administrator purchased a window alarm that would sound if the window had been opened. The staffing had changed to assign one aide to stay on each hall to keep a closer eye on the residents. When asked for the facility's policy on falls, the DON provided a copy of the protocol which had documentation of the following instructions: 1. When you see a resident who has fallen, do the following: a. Immediately go the resident, stay with the resident. b. If you are not a nurse, call for a nurse. c. Encourage the resident not to move. d. Ask them, "what were you doing just before you fell?" or "what were you trying to do just before you fell?" e. Begin getting answers to the "10 questions". f. Stay for the fall huddle, assist in getting a fall huddle started. 2. Fall Scene Investigation: a. Post fall investigation form. b. Data collection tool used to assess clues and evidence to determine Root Cause Analysis (RCA). c. Completed soon after the fall occurs and/or during the fall huddle. d. Completed by nurse in charge on duty at time	F 689		

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F 689	Continued From page 9 of fall. 3. Causation Findings Identified from the Fall Prevention Program: a. External causes: noise, busy activity, lack of environment contrasts, placement of furniture, equipment and personal items, floor surfaces. b. Internal causes: poor balance, sleep deprivation/sleep fragmentation, need for the 4 Ps, medications (type and amount), orthostatic blood pressure, lack of endurance. c. Systemic causes: time of day, shift change/times, break times, day of week, location of fall, type of fall, routine staff assignments, staffing levels.	F 689		

F689

Window alarm applied on 2/2/21 to resident #1 window. Also, multiple interventions as identified on resident #1 care place related to exit seeking behaviors.

Window alarms were placed on all high-risk residents' windows 2/2/21. Housekeeping will check those alarms daily to make sure they are functioning correctly.

The facility will place window alarms on all high-risk resident windows in the future upon and admission or as necessary.

The Director of Maintenance will review window alarm documentation weekly for 60 days. He will bring the results of these audits to QAPI for revisions if necessary.

2/8/2021