DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/08/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165177	A. BUILDING ______ B. WING ______	C 03/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HEALTH CENTER	231 NORTH EIGHTH AVENUE WEST HARTLEY, IA 51346

(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 Correction Date: 2/26/2021 3.3.21 The following deficiency is the result of the investigation of Incident #96021-I, completed on 2/23/21-3/1/21. Incident #96021-I was substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.)	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy and staff interviews the facility failed to ensure each resident received adequate supervision to prevent elopement for 1 of 10 residents identified by the facility with wanderguards, (Resident #1). Resident#1 exited the facility unsupervised and the facility failed to properly respond to an activated door alarm which resulted in immediate jeopardy to resident health and safety. The facility reported a census of 67 residents. Findings include: Resident #1 had a Quarterly Minimum Data Set (MDS) assessment dated 12/23/20, that documented a diagnosis of Alzheimer's Disease,	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janette Simon
TITLE: Administrator
(X6) DATE: 3/11/2021

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 Non-Alzheimer's Dementia, Anxiety, Depression and Chronic Pain. Resident #1 scored 5 of 15 on a BIMS (brief interview for mental status) test which indicated severely impaired cognition. The MDS documented the resident had signs of symptoms of delirium, inattention and disorganized thinking. The MDS documented no wandering and Resident #1 required supervision with locomotion off the unit and a walker for mobility device. A Potential Elopement Assessment dated 1/10/2020, documented: *Prior elopement attempts at home-no *One or more elopements attempts at facility-no *Alzheimer/dementia diagnosis-yes *Resident is very mobile with or without assistive devices-N/A, has wandergaurd Resident #1's Care Plan, dated as initiated 8/03/19, identified a focus area for injury, high risk for, potential for injury related to impaired thought processes, use of psychotropic medications, history of falls, occasional incontinence of bowel and bladder, interventions include: Wanderguard bracelet in use, check daily to ensure functioning properly, Change as need (PRN), see Electronic Treatment Administration Record (ETAR). Provide 1 assist for supervision with transfers/ambulation as allows. Transfer/ambulate with 4 wheeled walker. A Progress Note dated 2/16/2021 at 8:47 p.m., documented Resident #1 found in the Assisted Living. Staff accompanied resident back to the building safely. Wanderguard found not to be working. Wanderguard replaced. A Missing Resident Procedure/Drill dated 2/16/21	F 689		

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F 689	Continued From page 2	F 689		

at 7:30 p.m., documented the following:
5. e. alarm on/off - wanderguard changed. Resident walked with walker to adjoining assisted living. Assisted Living staff brought resident back. Made no attempt to exit doors to outside.
2. a. Time resident last seen: 7:20 p.m., at the nurses station
c. Were alarms on: Door alarm-yes, wanderguard not working
d. Time and place when resident was found-Assisted Living at 7:30 p.m.
e. Who found the resident-Assisted Living Personal Staff Assistant
f. Physical assessment done to determine injuries- no injuries noted

A summary written by the facility:
Time line of events on 2/16/21 and when last time seen/cared for by staff:

Certified Nursing Assistant (CNA) for Nursing home; last saw Resident #1 seated in dining room at approximately 7:00 p.m.-7:15 p.m.

Dietary Cook, saw resident at south nurses station talking with another CNA at 7:20 ish p.m.

CNA from Assisted Living, noticed resident walking in Living Room of Assisted Living at 7:30 p.m., and promptly took resident back through the door to the nursing home.

CNA saw resident again at "approximately 7:20 p.m.- 7:25 p.m." walking down East Hall with Assisted Living staff, CNA escorted resident back to resident room and assisted resident into a recliner.

Staff informed another CNA of the incident: Staff

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F 689	Continued From page 3 notified the Registered Nurse and they together checked the Wanderguard at the exit door between the nursing facility and the assisted living and discovered it was not working. The RN instructed the CNA to retrieve another wanderguard from the store room. Careplan: Note: Admission date on 7/26/19 from Community Memorial Assisted Living (attached to the nursing home) due to Alzheimer Diagnosis. History of Elopement attempts or wandering behavior: Wanderguard was included on care plan upon admission due to increased confusion. While resident never eloped from this door or any exit door, there was a threat of seeking out resident apartment because often traveled between the nursing home and the assisted living prior to moving to the care center. Diagram of floor plan: The distance from the door between the nursing facility and the assisted living to the assisted living room is approximately 100 feet. Staff Response to door alarm: RN heard door alarm and went to panel to read which door was sounding. RN discovered it was the door going into the Assisted Living. RN proceeded to the door and glanced into residents room on way. Not seeing anyone, RN returned to panel and shut off alarm. RN responded to CNA's when they told RN what had occurred by	F 689		

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F 689	Continued From page 4 participating in the wanderguard test and replacement, but this was approximately 30 minutes following the alarm. Approximately how long was the resident gone before assisted living staff returned resident: Approximately 5-10 minutes Process prior to addition the expiration dated to the Treatment Administration Record: Old process was to write in a notebook the residents name, date of activation, and date of expiration according to the back of the device. How did you know when to change the wanderguards? Wanderguards were tested daily (see attachment) by charge nurse and recorded on the Treatment Administration Record. The test light will blink GREEN four times to indicate the bracelet is transmitting a radio signal that can be detected by a monitored door. At 5:01 a.m. on 2/16/21, the Resident #1's device blinked GREEN. Plan of Correction: 1. RN (hire date of 1/21/21) was re-educated on 2/19/21; *Door alarms/procedures. *Resident alarm systems. *Elopement/missing person policy and procedure. 2. All staff education posted for Door Alarm procedure. Deadline; March 17, 2021 3. "NEVER SHUT OFF DOOR ALARM WITHOUT being 100% sure as to why it	F 689		

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F 689	Continued From page 5 sounded" was posted at the two door alarm panels yet to be reprogrammed on 2/17/21. Prior to COVID-19 we had a technician come to the facility and reprogram old door alarm system on the North side of the building so that it couldn't be shut off without having to be at the door which triggered the alarm. Our plan is to reprogram the other two panels. On 2/17/21, technician was contacted to schedule when could come back in, he thought Monday 2/22/21. 4. QAPI for door alarms audits will be conducted on all doors, all shifts and continues until all responses are correct for 3 months. Beginning 2/22/21. 5. Wandering resident policy reviewed by the Director of Nursing on 2/18/21. 6. Wanderguard activation, documentation, and testing policy was reviewed and updated by the Director of Nursing on 2/19/21. Education for all licensed nurses will be done by March 17, 2021. Orientation materials for new hires includes updated policy and new policy included in nursing policy binders for reference on 2/19/21. 7. All residents with wanderguards were reviewed on 2/18/21 for expiration dates on device and 90 day activation dates to be sure noon have expired on either date. None were found. 8. Two new universal testers for wanderguards ordered to have as backups for current devices on 2/19/21. 9. New system for tracking wanderguards implemented on 2/19/21. a. On tote with Wanderguards are instructions for wanderguard activation and documentation. 1. Activate Wanderguard system. 2. Record date of activation on TAR 3. Set replacement alert for 90 days from activation or expiration date of device (located on	F 689		

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F 689	Continued From page 6	F 689		

back) whichever comes first.

b. Educated licensed nursing staff to new procedure and policy updates. Deadline March 17, 2021.

10. All exit doors in the Assisted Living will have alarms on them. Technician will place exit door alarms that send signals to personnel pager when triggered. Each exit door will have key pad code. Contact was made on 2/19/21 to schedule work.

During an interview on 2/24/21 at 2:15 p.m., Staff A (CNA), stated she down the long hall in the Assisted Living on 2/16/21 and heard someone talking out by the living room, so Staff A went to the living room, looked at the hall clock, which read 7:30 p.m., and found Resident #1 with a 4 wheeled walker, saying "I just don't know, I just don't know". Staff A was able to identify the resident as the resident used to live in the Assisted Living. Staff A took Resident #1 back to the nursing facility through the south east door of the facility. Resident #1 had told Staff A she was tired and could not walk any further so Staff A had the resident sit down on the seat of her walker and pushed her back to the nursing home side. Staff A stated the wanderguard on the resident walker failed to sound as the resident went through the doors. Staff A stated she was met by another CNA in the hallway by the residents room who took over and then Staff A went back to the Assisted Living.

During an interview on 2/23/21 at 5:15 p.m., Staff B, CNA, stated that around 7:30 p.m., on 2/16/21, Staff B saw Staff A pushing Resident 1# through the southeast door of the facility. Resident #1 was sitting on the seat of the 4 wheeled walker. Staff B stated she assisted the resident into the recliner in her room and then proceeded to notify

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F 689	Continued From page 7 the RN on duty that Resident #1 had left the facility unattended. Staff B stated she last saw the resident in the dining room around 7:00 p.m., then left the dining room to attend a call light that was on. Staff B stated she didn't hear a door alarm or the wanderguard alarm sound as the resident left the hallway. During an interview on 2/24/21 at 12:15 p.m., Staff C, CNA, stated she had worked the evening shift on 2/16/21 and she had last seen Resident #1 ambulating down the hallway with a 4 wheeled walker between 7:00 p.m.-7:10 p.m. Staff C stated she thought the resident was going to her room so Staff C proceeded to do her job duties on the south west end of the facility. Staff C stated around 8:00 p.m., staff were at the nurses station visiting about Resident #1 leaving the facility and the resident wanderguard failed to sound. Staff C stated she went into Resident #1's room and grabbed the walker and proceeded to go to the southeast door and the alarm failed to activate, so Staff C then took the walker with the wanderguard on it and went to the east door in the dining room and the wandergaurd failed to sound at that door also. Staff C stated she told the RN on duty to go and get a new wanderguard, activate the wanderguard and then Staff C went into Resident #1's room and placed the new activated wanderguard on the residents left wrist and removed the wanderguard that failed to alarm from the 4 wheeled walker. During an interview on 2/23/21 at 4:10 p.m., Staff D (Register Nurse) stated he had worked the evening shift on 2/16/21. Staff D stated he heard the southeast door alarm sound, not sure of the time, proceeded to walk over to the panel on the north side of the hall, across from the nurses	F 689		

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F 689	Continued From page 8 station and noticed that the alarm was red and said south east door. Staff D stated he proceeded to walk down the southeast hallway and look into the resident rooms. Staff D said he looked through the window on the south east door, didn't see anything, proceeded to shut the door alarm off, walked back to the alarm on the panel that was sounding and flipped the switch to re-activate the southeast door alarm. Staff D stated he didn't go through the southeast door to verify that it was a resident or staff member. Staff D said he was notified by Staff B about 7:30 p.m., that Resident #1 had left the facility unattended and was found in the Assisted Living area. Staff D then proceeded to do an assessment on the resident, found no injuries and went back to passing medications. During an interview on 2/24/21 at 4:00 p.m., the facility Director of Nursing (DON) stated it is an expectation of the charge nurse to verify that when a door alarm is sounding to physically go out the door and check to see if it was a resident or staff member and if they fail to see anything they need to put into place the Missing Resident policy and procedure and follow the guidelines before re-activating the door alarm. During an interview on 2/24/21 at 9:15 a.m., the facility Administrator confirmed and verified the wandergaurd system failed by not sounding as Resident #1 went through the southeast door of the facility. Upon the facilities investigation, the wandergaurd was activated on 11/15/20 and reading the manufacturers guidelines after 90 days the wanderguard needs to be removed from the resident and a new wanderguard placed on, that would mean on 2/15/21 Resident #1 should of had a new wanderguard placed on their	F 689		

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F 689	Continued From page 9	F 689		

person. The other system that failed was the RN on duty that evening failed to physically go through the southeast door to verify if the door alarm sounded due to a resident leaving the facility or a staff member that was leaving. The Administrator stated the expectation of the nursing staff is to verify if it was a resident or staff leaving prior to shutting off the alarm and re-activating the alarm again on the control panel.

During an environmental tour on 2/23/21 at 3:20 a.m., the facility Assistant Director of Nursing and surveyor went around to all the door alarms and they all sounded and staff responded quickly to the door and wanderguard alarms.

The distance from where the resident was last seen in the facility to the Assisted Living area was 120 surveyor steps for which there was a door leading out into the parking lot of the facility and a brown door leading into the Assisted Living area that Resident #1 went through.

The Weather Underground for 2/16/21, documented the temperature at 6:56 p.m., -2 degrees Fahrenheit, with the wind out of the southeast at 10 miles per hour and the low of -27 degrees.

Review of the Wandering Resident policy dated 2021 documented:
Policy: It is the policy of the Community Memorial Health Center to identify and protect the wandering resident.
Purpose: To maintain a safe environment for the wandering resident.
Procedure: Families will be informed on admission and sign a statement that residents will receive the least restrictive physical and chemical

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F 689	Continued From page 10	F 689		

restraints possible to assure safety, however, the facility is unable to guarantee the resident will not elope.
A. An alarm system is connected to all exit door.
B. All residents will have a photograph in their medical record for identification purpose.
C. Wandering residents will be identified on their care plan with appropriate goal and approaches.
D. Staff members will be inserviced yearly in accordance with State and Federal regulations. The agenda of the inservice will include:
1. The identification of wandering residents.
2. The identification of potential environmental hazard: parking lots, street, parks. etc.
3. How to prevent and deal with the wandering resident.
4. The procedure for missing residents.
5. How to relocate wandering residents who cannot be protected.
6. The procedure for contacting the police and/or family.

Review of the Stanley (First Q) Wanderguard departure alert system, user instructions with no date documented:
Warning- Do not place the signaling device on or next to metal, such as wheelchair frames, jewelry, watches, etc, or allow it to come in contact with a door or associated hardware such as crash-bars, push-bars, etc, metal could interfere with the signal sent to the door modules.
Signaling device activation:
1. Note the date on the back of the device. This is the last day the device can be activated to provide approximately 90 days of useful life. Record the date in the residents record.

The facility was notified of the immediate

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F 689	Continued From page 11 jeopardy and given the IJ template on 2/25/21 at 12:00 p.m. The immediate jeopardy was removed on 2/26/21 as the facility provided education to all staff on Elopement Risk/Elopement (Missing Resident) Process and that all staff will check any door alarm that sounds for a resident that went through or a staff and never shut off door alarm without being 100% sure as to why it sounded". Wandering Resident policy reviewed with all staff and Wanderguard Activation, Documentation and Testing policy reviewed by all staff. At the time of exit, the scope and severity was lowered to an D.	F 689		

Plan of Correction for State Statement of Deficiencies

Community Memorial Health Center

231 N 8th Ave W
Hartley, IA 51346-0188
Survey Date: February 23-March 1, 2021

F689 481-58.28 (135C) Safety

58.28 (3) Resident Safety

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1. 2.16.2021 at approximately 8:00 p.m. C.N.A. replaced the WanderGaurd with a new and functioning device on Resident #1 as she re educated RN, charge nurse as to the correct procedure.
2. "NEVER SHUT OFF DOOR ALARM WITHOUT being 100% sure as to why it sounded" was posted at the door alarm panels on 2.17.2021.
3. Wandering Resident Policy reviewed by DON on 2.18.2021.
4. All residents with WanderGuards were reviewed on 2.18.2021 for expiration dates on device and 90 day activation dates to be sure none have expired on either date. None were found.
5. RN was reeducated prior to working again on 2.19.2021:
   - Door Alarms/Procedures
   - WanderGuard Activation, Documentation, and Testing Policy
   - Missing person policy and procedure
6. On 2.19.21 an all staff education was posted and all staff will be educated on Door Alarm response procedure prior to working on schedule. All staff educated on 2.26. 2021.
7. WanderGuard Activation, Documentation, and Testing Policy was reviewed and updated by DON on 2/19/2021. Education for all licensed nurses was completed by 2.26.2021. Orientation materials for newly hired license nurses includes updated policy and new policy included in nursing policy binders for reference on 2.19.2021.
8. 2 new Universal Testers for WanderGuards arrived from Stanley Technologies to have as backups for current devices on 2.23.2021.
   a. New system for tracking WanderGuards implemented on 2.19.2021._All licensed nursing staff were educated to new procedure and policy by 2.26.2021.
9. QAPI for door alarms audits will be conducted on all doors, all shifts and continued until all responses are correct for 3 months. Beginning 2.22.21.
10. On 2.25.2021 education was written for a licensed nurse to review what needs to be done during and after a missing person/ elopement event i.e.charting, assessments, notifications. All licensed nurses were educated by 2.26.2021.
11. Technician completed rewiring all exit doors to key pad shut off on 2.26.2021.
12. All Exit doors in the Assisted Living have Wander Guard systems installed. All exit doors were be alarmed with shut off at key pad on 3.3.21.