

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: #5333		Date: 7/29/21		
Facility Name: Westwood Specialty Care		6/29-7/1/21, 7/6-8/21, 7/12-14/21 and 7/19/21		
Facility Address/City/State/Zip 4201 Fieldcrest Drive Sioux City IA 51104				
SB				
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

58.28(3)e,f	<p>481—58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)</p> <p>58.28(3) Resident safety.</p> <p>e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)</p> <p>f. Residents shall be protected against physical or environmental hazards to themselves. (I, II, III)</p> <p>DESCRIPTION:</p> <p>Based on observations, clinical record and policy review, resident and staff interview, the facility failed to adequately supervise residents at risk for elopement for 1 of 3 residents reviewed (Resident #1). On 6/27/21, the resident left the facility without staff knowledge and propelled himself in in his wheelchair to the south side of the facility and down a hill. On 7/10/21, the resident again left the facility in his wheelchair without staff knowledge (a second elopement) through the kitchen service door. The facility also failed to provide adequate supervision for residents during active construction in the resident hallways for 1</p>	I	\$10,000 (Held In Suspension)	UPON RECEIPT
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Facility Administrator

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	<p>of 3 residents reviewed (Resident #4) who fell due to torn up flooring from construction. The residents fall resulted in a displaced fracture to the left ankle, and involved the tibia and fibula. Facility census was 77 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) for Resident #1 with a completion date of 6/22/21, identified a Brief Interview for Mental Status (BIMS) score of 1 (severe cognitive impairment and decision making skills). The MDS documented the resident exhibited wandering on 1-3 days of the 7 day look back period. The resident required limited assistance of 1 staff for transfers, and supervision with 1 person physical assistance for locomotion on and off the unit. The MDS documented diagnosis of Non Alzheimer's Dementia and anxiety. The resident admitted to the facility 6/8/21.</p> <p>The Care Plan with initiation date of 6/14/21, identified the resident at risk for elopement &/or wandering related to history of attempts to leave the facility unattended and wandering aimlessly. The care plan interventions included: alert staff to wandering behavior (6/14/21); if wander away from the unit, staff stay with the resident (6/14/21), converse and gently persuade the</p>			
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	<p>resident to walk back to the designated area (6/14/21); note which exits are favored for elopement from the facility and alert staff working in those areas (6/14/21); monitoring device placed that sounds alarm when leaving the building; provide diversional activities (6/14/21); and assign staff to account for my whereabouts throughout the day, one to one (7/12/21). The care plan with initiation date of 6/10/21, identified the resident enjoyed reading, food activities, listening to country music, being around animals, watching the television, and being outside.</p> <p>The Admission Wandering Evaluation dated 6/8/21, identified the resident high risk for wandering with a score of 10, due to: independently ambulates, independent with wheelchair, diagnosis of dementia & orientation, and history of wandering. A total score of 10 or higher indicated wander guard bracelet (monitoring device designed to activate an alarm if the resident attempts to leave the building) needed to be applied.</p> <p>The Significant Change Wandering Evaluation dated 6/12/21, identified the resident as high risk for wandering with a score of 12, due to: statements of wanting to leave the facility, anxious behavior, independent with wheelchair,</p>			
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	<p>diagnosis of dementia & orientation, and attempts to leave facility since admission.</p> <p>The progress notes revealed:</p> <p>a. 6/8/21 at 8:18 AM, Admit - the resident arrived at the facility accompanied by brother and sister in law. The resident orientated to person and place with impaired decision making ability. The resident confused and forgetful.</p> <p>b. 6/10/21 at 4:38 PM, activity - one to one with the resident outside in the gazebo.</p> <p>c. 6/12/21 at 11:58 PM, incident - the resident wheeled himself to the emergency exits and front entrance throughout the facility.</p> <p>d. 6/13/21 at 2:38 AM, focused evaluation - staff continued to monitor the resident for exit seeking behaviors. The resident rested quietly in bed this shift, came out of his room one time in wheelchair and asked "where's everyone at?" Staff re-orientated the resident and assisted him back to bed. The wander guard on wheelchair and functioning. The resident displayed no exit seeking behaviors.</p> <p>e. 6/15/21 at 3:37 AM, focused evaluation - the resident got up at 3:00 AM, reported not sleeping. The resident wandered around the facility in wheelchair, no behaviors and pleasant mood. The resident offered the bathroom and snack, refused.</p>			
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	<p>f. 6/15/21 at 6:58 PM, focused evaluation - the resident attempted to exit the door, returned to his room to watch television.</p> <p>g. 6/19/21 at 12:04 AM, focused evaluation - the resident roamed throughout the common areas in the facility, observed looking out the windows but does not appear interested in opening the doors. Constant supervision provided to the resident. Wander guard in place and successfully tested.</p> <p>h. 6/20/21 at 8:20 PM, focused evaluation - the resident wandered this shift in wheelchair independently. The resident looked at picture books in the dining room.</p> <p>i. 6/21/21 at 2:28 AM, focused evaluation - the resident wandered throughout the shift despite redirection attempts, encouragement and reminders by staff. The resident read items posted on bulletin board and the newspaper. The resident did not appear to exit seek, roaming.</p> <p>j. 6/23/21 at 2:57 PM, focused evaluation - the resident asked the nurse to take him home after lunch, easily re-directed.</p> <p>k. 6/27/21 at 2:18 AM, focused evaluation - the resident had no exit seeking behaviors.</p> <p>l. 6/28/21 at 1:52 AM, focused evaluation - the resident exit seeking 2 times, out the 600 & 700 hall doors with the wander guard alarm sounding. The resident sat at the nurse's station</p>			
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	<p>and offered snack. The resident toileted and assisted to bed at 1:45 AM.</p> <p>m. 6/28/21 at 2:17 PM, focused evaluation - the resident continued to exit seeking. The resident goes to several halls at different times, opened doors and exits facility. The resident not easily re-directed and upset with staff.</p> <p>The progress notes revealed no documentation that Resident #1 left the facility without staff knowledge (eloped) or of an assessment of the resident upon the return to the facility following an elopement on 6/27/21.</p> <p>The facility document titled Elopement Prevention dated January 2015, directed:</p> <ul style="list-style-type: none"> a. Evaluate all residents for potential of elopement from the facility b. For new admissions, review any history of elopement and behavior patterns in prior living arrangement c. Evaluate and identify factors for potential elopement from the facility: Alzheimer/dementia, mobility, medication, aimless wandering, verbally expresses desire to leave, effect of new environment on behavior, perimeter wandering, and/or sudden change in behavior. d. Provide wander guard bracelet to all residents determined to have a potential for elopement 			
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	<p>e. Take identification picture on admission and update with care plans</p> <p>f. Document all attempts for elopement and evaluate precipitating factors. Document effect measures taken to return the resident to the facility</p> <p>g. Assess the resident's ability to remain in the facility safely</p> <p>h. The resident care plan will contain interventions and actions to monitor and prevent elopement.</p> <p>i. All staff respond promptly to all door alarm activations. If immediate reason for the door alarm is not determined, all residents will be accounted for at that time.</p> <p>j. All door alarms checked daily by a Quality Assurance (QA) team member to make sure they are working properly. QA will document conditions of the alarms.</p> <p>k. Quarterly elopement drills are highly recommended: all staff are involved in elopement drills, send a person out to hide where a resident might elope to, initiate the search, note time and place the resident found, keeps records for QA, and have staff work on problem solving.</p> <p>The facility procedure titled Missing Resident undated, indicated upon notification that a resident is missing, the following procedure will be implemented:</p>			
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	<p>a. If after normal business hours, notify the Administrator</p> <p>b. Assemble all department heads</p> <p>c. Organize and institute a thorough search of the facility and the surrounding grounds and buildings</p> <p>d. If a search of the facility and grounds is not successful, notify the next of kin</p> <p>e. Notify the local law enforcement</p> <p>f. Recall off-duty personnel as needed</p> <p>g. Notify local civil defense agency and request search assistance if needed</p> <p>h. Contact volunteer assistance groups for additional search personal</p> <p>i. Organize and institute an expanding search of neighborhood surrounding the facility</p> <p>j. Notify know relatives, friends, and favorite stopping places that the resident is missing</p> <p>k. When the resident is located, notify all agencies and individuals involved in the search that the resident had been found</p> <p>The facility document titled Missing Resident revised 12/7/09, stated the facility would maintain a list of residents identified at risk for exit seeking. The list will be kept at the Nurses station and include the resident's picture and pertinent information on each resident listed. Upon notification that a resident missing:</p>			
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	<p>a. If off duty hours, notify the Administrator and Director of Nursing (DON)</p> <p>b. Assemble all available department heads</p> <p>c. Organize and institute a thorough search of the facility</p> <p>d. If a search of the facility and grounds failed to locate the missing resident, notify the next of kin</p> <p>e. Notify local law enforcement</p> <p>f. Recall off duty personnel as needed</p> <p>g. Notify the Divisional Director and the Nurse Consultant</p> <p>h. Notify the Director of Safety</p> <p>Observations of Resident #1 on:</p> <p>a. 6/29/21 at 3:49 PM, in his wheelchair, at the dining room table with fellow residents. Wander guard transmitter located on the resident's wheelchair.</p> <p>b. 6/29/21 at 5:05 PM, sat in wheelchair by the front door of the facility. The resident with eyes closed and head down. Wander guard transmitter located on left side of wheelchair.</p> <p>c. 6/29/21 at 5:41 PM, propelled self in wheelchair to the dining room and transferred self to dining room chair.</p> <p>d. 6/30/21 at 8:54 AM, propelled self out to the dining room table in wheelchair, and visited with fellow residents.</p>			
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	<p>e. 6/30/21 at 10:33 AM, in recliner in his room with eyes closed</p> <p>f. 6/30/21 at 1:30 PM, at dining room table in wheelchair, wander guard transmitter on wheelchair</p> <p>g. 6/30/21 at 6:00 PM, at the dining room table in wheelchair, consumed 100% of meal.</p> <p>h. 7/1/21 at 7:50 AM, at dining room table in wheelchair with wander guard transmitter in place on wheelchair</p> <p>i. 7/1/21 at 8:25 AM, the transportation driver propelled the resident to the front door, told the resident leaving for an appointment at the Veterans Clinic. Wander guard alarm sounded as the resident was assisted through the front door by the transportation driver.</p> <p>j. 7/1/21 at 10:42 AM, returned to the facility with the transportation driver. The door alarm and wander guard alarm sounded as the resident is assisted through the front door.</p> <p>k. 7/1/21 at 2:10 PM, sat at the end of the 100 hall by the nurse's station in wheelchair. The resident well groomed, non-skid footwear and wander guard on wheelchair. The resident propelled self to the 200 hall and turned around, returned to the nurse's station.</p> <p>l. 7/6/21 at 11:29 AM, in recliner in room, eyes closed. The wheelchair placed beside the recliner.</p>			
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	<p>m. 7/6/21 at 2:29 PM, lying in bed facing the wall at this time. The wheelchair placed beside the bed.</p> <p>n. 7/7/21 at 10:15 AM, sat in wheelchair at dining room table, wander guard on wheelchair. The resident visits with fellow residents.</p> <p>o. 7/7/21 various times throughout the afternoon Resident #1 at the front door of the facility, stated he wanted to leave. The resident asked about getting key to collect the garbage. Resident #1 asked Resident #2 to punch in code so they could go outside. Resident #1 did not open the front door at any time and easily re-directed by facility staff. The resident in wheelchair at all times.</p> <p>p. 7/8/21 at 9:56 AM, sat at the dining room table with fellow residents, wander guard on wheelchair.</p> <p>Observation on 6/30/21 at 1:20 PM, by the surveyor of the area where the resident was found in his wheelchair on 6/27/21 related to the location of the facility. The observation showed the resident crossed the street, went downhill, and ended up located at an incline in the driveway with 3 cars present. The distance the resident traveled from the facility could vary from 159 - 175 steps depending on the door he exited the facility from. It took the surveyor</p>			
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	<p>approximately 3 minutes to continuously walk the distance without any stops.</p> <p>On 6/30/21 at 4:20 PM, door alarm check completed with the Administrator and Staff X Licensed Practical Nurse (LPN) revealed Staff X opened the door at the end of 200 hall, only door alarm sounded. The local red box alarm did not sound. Observation at that time showed the red box alarm located at the top of the door (local alarm) turned to the "OFF" position. Staff X turned red box alarm on and proceeded to open door, both alarms sounding. The Administrator stated she did not know why the alarm turned to "OFF". The front door, south dining room door, north dining room door and 500 hall contained wander guard alarms and door alarms. The 100, 200, 300, 600, and 700 hall door contained door alarms and local red box alarms in place.</p> <p>On 6/29/21 at 4:26 PM, Staff E Certified Nurse's Aide (CNA) stated she headed into the facility on 6/27/21, for her scheduled shift at 2:00 PM and observed Resident #1 in his wheelchair, 3-4 houses down the hill from the facility. Staff E stated Resident #1 went across the street, down the hill, and sat in a driveway. Staff E stated she went to the resident as he sat next to the sloped section of the driveway. She observed the resident wore slacks, short sleeve shirt, hat, and</p>			
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	<p>glasses. Staff E stated Resident #1 told her he could not get up the hill. Staff E identified the weather as "hot" on 6/27/21. Staff E stated she did not observe any injuries, bruising or bleeding to Resident #1. Staff E stated Resident #1 had a history of exit seeking and setting off the alarms. Staff E confirmed Resident #1 had a wander guard transmitter in place on the wheelchair. Staff E stated when Resident #1 returned to the facility, staff did not know he was missing. Staff E stated when Staff F CNA arrived at the facility for her scheduled shift on 6/27/21, Staff F observed the resident being assisted up the hill back to the facility, and inquired what occurred. Staff E stated an agency nurse also arrived for her scheduled shift at that time and observed the resident being returned to the facility. Staff E stated she took Resident #1 into the facility through the front doors and entered the door alarm code when she entered. The wander guard alarm did sound upon entrance. Staff E stated she took Resident #1 to the nurse's station and notified Staff G LPN (licensed practical nurse) that she found the resident outside and down the hill from the facility without staff with him. Staff E stated she did not know if Staff G LPN completed an assessment of Resident #1. Staff E stated it was the weekend and no administrative staff worked so she placed a note under the Administrator's door of the incident. She did not receive call from the facility</p>			
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	<p>regarding the incident. Staff E stated Resident #1 had a history of exit seeking behaviors, and got to the door previously but staff intervened. Staff E stated the facility did not provide any education after the 6/27/21 incident with Resident #1. Staff E stated she did not know what door Resident #1 exited from and the resident would not be able to confirm what door he exited. Staff E identified concerns for Resident #1's safety due to the potential of rolling into the street &/or tipping out of his wheelchair. Staff E stated she informed Staff G LPN that she left a note for the Administrator regarding the incident.</p> <p>On 6/30/21 at 1:04 PM, Staff F CNA stated when she arrived to her scheduled 2:00 PM shift on 6/27/21, she observed Staff E CNA propelling Resident #1 up the hill back to the facility. Staff F stated she asked Staff E what occurred and Staff E informed her Resident #1 had been down the hill in a driveway across the street. Staff F stated the 2 CNA's assisted the resident inside the facility and took him to the nurse's station and staff had no knowledge the resident had gone outside. Staff F stated she informed Staff G LPN Resident #1 went outside and Staff G responded "okay". Staff F stated to silence the alarms, staff on duty at the time would have to go to the door to shut off the alarm, and staff waited too long to shut off and then did not observe Resident #1</p>			
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	<p>outside. Staff F stated the CNA's on duty at the time did not know the resident was missing. Staff F stated Resident #1 appeared he was outside for a while and was sweating. Staff F stated the resident wore pants and long sleeve shirt.</p> <p>On 6/30/21 at 9:26 AM, Staff G LPN confirmed she worked the day shift on Sunday 6/27/21. Staff G stated Resident #1 frequently tried to leave the facility and stated the resident set the alarms off and staff would respond. Staff G stated Resident #1 attempted to leave the facility earlier in the day, before noon, on 6/27/21. Staff G stated the door alarm and the wander guard alarm sounded, she responded and Resident #1 did not get outside. Staff G denied staff reported to her that they found Resident #1 outside unattended on 6/27/21. Staff G denied Resident #1 ever outside the facility unattended or off the facility grounds. Staff G stated she was not aware of Resident #1 off the facility grounds on 6/27/21 and denied any CNA reported this to her.</p> <p>On 6/30/21 at 8:08 AM, Staff H CNA confirmed she had worked the day of 6/27/21. Staff H stated no residents attempted to leave the facility on 6/27/21, and no door alarms sounded. Staff H stated door alarms only sound when the manager on duty checks the doors. Staff H stated Resident #1 set the door alarms off when he attempted to</p>			
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	<p>leave the facility a few days after admission to the facility, and Staff H did not know of any other time.</p> <p>On 6/30/21 at 11:03 AM, Staff H CNA identified the last time she observed Resident #1 as at noon meal on 6/27/21. Staff H revealed the noon meal finished around 1:00 PM, and she passed lunch trays. Staff H identified Resident #1 in the dining room at the table, at that time. Staff H stated she did not recall making observation of Resident #1 after that time. Staff H stated when she left the facility for the day at approximately 2:00 PM, she did not observe the resident. Staff H stated she did not know of any alarms not functioning and unaware of any other residents out of the facility undetected. Staff H stated she may have turned an alarm off on 6/27/21 after breakfast.</p> <p>On 6/30/21 at 8:15 AM, Staff I CNA confirmed she worked the day shift on 6/27/21. Staff I stated no residents attempted to leave the facility undetected and she did not recall any door or wander guard alarms sounding. Staff I stated if a resident had a wander guard transmitter on, 2 alarms activated if the resident attempted to leave the facility. Staff I stated Resident #1 never attempted to leave the facility while she was on duty. Staff I stated Resident #1 asked frequently</p>			
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Facility Administrator

Date

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Health Facilities Division
Citation**

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	<p>about going out to pick up furniture, go up and down the halls, and look out the windows, however, he never left. Staff I stated she would remember if Resident #1 tried to leave on Sunday 6/27/21. Staff I stated she left the facility at 2:00 PM on 6/27/21, and stated someone told her to go look at Resident #1 before she left, as he was asleep in another resident's bed.</p> <p>On 6/30/21 at 12:05 PM, Staff I CNA stated she did not recall how long Resident #1 stayed in the dining room after the noon meal on 6/27/21. However, stated she believed she saw Resident #1 in Resident #2's bed between 1:00 - 1:30 PM. Staff I took garbage out when she observed the two residents in Resident #2's room. Staff I identified Resident #1 as in a pleasant mood. Staff I never observed him agitated.</p> <p>On 6/30/21 at 1:55 PM, Staff W Housekeeping stated on 6/27/21 she worked down hall 200 at 9:00 AM and cleaning in room 201 and observed Resident's #1 & #2 ambulating down the hall and within short time, heard alarm sounding. Staff W stated Staff G LPN and herself responded to the alarm at the front door and found Resident #1 in the breezeway. Staff W stated Resident #1 easily re-directed and returned into the facility.</p>			
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	<p>On 6/30/21 at 9:06 AM, Staff J CNA confirmed she worked 6:00 AM - 10:00 PM on Sunday 6/27/21. Staff J stated she did not know of Resident #1 attempting to leave the facility unattended on 6/27/21, and did not recall door alarms or wander guard alarms sounding. Staff J stated Resident #1 would try to leave the facility, however, the alarm would sound and staff would immediately respond. Staff J stated she never saw Resident #1 get out of the facility.</p> <p>On 6/30/21 at 9:16 AM, Staff K LPN confirmed she worked on Sunday 6/27/21. Staff K stated she did not remember any resident attempting to leave the facility on 6/27/21. Staff K stated Resident #1 frequently attempted to leave the facility. Staff K denied knowledge of Resident #1 attempting to leave the facility on 6/27/21, as she was not his nurse. Staff K stated alarms always go off, and when she responded, someone already took care of the alarm. Staff K stated no one reported to her that Resident #1 eloped from the facility. Staff K stated residents' wander guard transmitters are checked every shift for placement and functioning. Staff K stated the weekend manager came in to check the door and wander guard alarms, and checked them on Saturday 6/26/21.</p>			
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	<p>On 6/30/21 at 11:11 AM, Staff T CNA confirmed she worked the day shift on 6/27/21. Staff T stated she did not recall Resident #1 agitated or upset. Staff T stated she heard about the resident found outside the facility after the incident occurred. Staff T stated she informed the evening shift to keep an eye on Resident #1 due to the incident that occurred on the day shift. Staff T then identified Resident #1 as "irritated" on 6/27/21 but did not know why. Staff T stated she did not see Resident #1 at the exit doors and she did not turn off any alarms on 6/27/21. Staff T stated staff cannot turn alarms off unless after physically looking outside first. Staff T stated she questioned if the alarm sounded when Resident #1 exited the facility on 6/27/21 but no one responded to her question. Staff T stated she did not know of alarms not functioning and unaware of any other residents outside without staff aware.</p> <p>On 6/30/21 at 11:21 AM Staff U CNA confirmed she worked on the day shift 6/27/21. Staff U identified her last observation of Resident #1 on 6/27/21 as in the dining room before breakfast. Staff U stated the resident wanders throughout the building frequently. Staff U could not recall the resident making comments about leaving the facility on 6/27/21.</p>			
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	<p>On 6/30/21 at 11:32 AM, Staff O RN stated she arrived at work on 6/27/21 at 6 PM. When she arrived, she observed Resident #1 at the front door with the wander guard alarm sounding. Staff O stated the staff followed the resident into the breezeway and returned him into the facility. Staff O stated Resident #1 had history of exit seeking behaviors.</p> <p>On 6/30/21 at 11:53 AM, Staff V RN stated when she arrived at the facility on 6/27/21 for her scheduled shift at 2:00 PM, observed a CNA bringing Resident #1 back into the facility. Staff V stated the incident did not look unusual and she did not know the resident eloped out of the facility unattended. Staff V stated the facility staff informed her to keep all alarms on due to Resident #1 attempting to leave the facility.</p> <p>On 6/29/21 at 5:52 PM, Staff A LPN stated the wander guard alarms are located only on the normally exited doors; the front door, the 500 hall, and the north & south dining room doors. Staff A stated all other exit doors have a door alarm that sounds at the nurses station. Staff A stated the doors without a wander guard alarm contain a handle alarm and a red box local alarm located at the top of the doors, that sounds separately from the door alarm. Staff A stated the exit doors contain a red alarm or a wander guard alarm, in</p>			
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	<p>addition to the door alarm. Staff A stated the wander guard transmitter, located on the resident, is checked every shift and documented on the respective resident's treatment administration record (TAR). Staff A stated the transmitters are replaced every 90 days, and as needed. Staff A proceeded to demonstrate how to check the wander guard transmitter. Staff A identified 2 current residents that attempt to leave the facility, however, staff have intervened prior to them exiting the facility. Staff A identified one of those residents as Resident #1. Staff A stated all staff respond to alarms that sound. Staff A denied knowledge of any residents leaving the facility undetected.</p> <p>On 6/29/21 at 6:05 PM, Staff B CNA identified Resident #1 with active exit seeking behaviors, confusion, and wandering. Staff B stated staff re-directs Resident #1 frequently while exit seeking. Staff B denied knowledge of Resident #1 leaving the facility undetected.</p> <p>On 6/29/21 at 6:07 PM, Staff C Registered Nurse (RN) stated she worked the night shift. Staff C stated Resident #1 displayed exit seeking behaviors during the night shift. Staff C stated Resident #1 exited the facility, in direct sight of staff, and returned to the facility. Staff C stated staff provided food and fluids to the resident,</p>			
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	<p>however, the resident continued to go up and down the halls. Staff C stated staff checks wander guard transmitters every shift for functioning.</p> <p>On 6/29/21 at 6:09 PM, Staff D LPN stated she worked the 2-10 PM shift. Staff D denied knowledge of Resident #1 leaving the facility undetected. Staff D stated there one time the resident exited and the alarm activated. Staff brought the resident back inside and another time the resident stood at the doorway of the facility with the door open. Staff D stated she did not know the date Resident #1 was outside, however, it occurred at the North dining room door.</p> <p>On 6/30/21 at 10:24 AM, the Regional Director of Clinical Services stated the facility did not have cameras inside the facility or outside on the facility grounds. The Regional Director of Clinical Services stated the facility needed to complete a self-report regarding the 6/27/21 elopement. The Regional Director of Clinical Services stated Staff E CNA left a note for the Administrator on Sunday 6/27/21, regarding an elopement. The Regional Director of Clinical Services stated the Administrator observed 3 notes when she arrived at work on Monday 6/28/21, however, had not read the notes until today 6/30/21. The Regional Director of Clinical Services stated they were conducting interviews, working on staff education,</p>			
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	<p>and the charge nurse in question suspended until investigated. The Regional Director of Clinical Services stated Staff G LPN informed her she did not recall anyone informing her of Resident #1 found outside. The Regional Director of Clinical Services identified the facility in process of notifying Resident #1's primary care provider, family, and on line report to DIA.</p> <p>On 6/30/21 at 6:05 PM, the Regional Director of Clinical Services stated she could not locate an elopement drill for the last year, as directed in the facility policy.</p> <p>On 6/30/20 at 10:04 AM, the State climatologist reported the temperature on 6/27/21 at 1:00 PM, 81 degrees with north/northwest wind 6 miles per hour (mph) and heat index of 82 degrees. The state climatologist reported the temperature at 2:00 PM, 81 degrees with a calm wind, heat index of 82 degrees, and scattered showers in the area.</p> <p>On 6/30/21 at 2:32 PM, the Administrator stated she had been employed at the facility for short time and when she arrives at work will have notes under her door. The Administrator stated notes are requests to visit with certain residents. The Administrator stated this week she tried to get staffing filled and pushed the notes to the side on Monday 6/28/21 and did not read them. The</p>			
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	<p>Administrator stated she read the notes today (6/30/21) and read the note regarding Resident #1 found outside the facility on 6/27/21 by staff who arrived to work for their scheduled shift at 2:00 PM.</p> <p>On 6/30/21 at 4:57 PM, the Administrator identified the alarm log as weekly alarm checks. Maintenance previously completed the checks daily. The Administrator stated the alarm log matched the weekend manager's duty assignment sheet for weekly check. The Administrator stated the facility did not currently have a full time maintenance employee so maintenance currently not completing daily checks. The Administrator and surveyor checked the red box alarm on the 200 hall door exit and found the alarm in the off position during alarm checks. The Administrator confirmed the observation and stated the facility would have to start to complete daily alarm checks instead of weekly.</p> <p>On 7/8/21 at 10:13 AM, the Administrator stated she expected facility staff to call herself &/or the Director of Nursing (DON) when staff found Resident #1 outside the facility unattended on 6/27/21. The Administrator stated she expected the nurse to complete an assessment after the nurse determined the resident safe. The</p>			
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	<p>Administrator stated she expected staff to notify the resident's family and primary care provider of the elopement. The Administrator stated she would have filed a report with DIA within 24 hours of the elopement and within 2 hours, if the resident received an injury. The Administrator stated once the resident safe; determine what happened, obtain staff statements, and put interventions in place to prevent.</p> <p>Second Elopement for Resident #1 that occurred on 7/10/21:</p> <p>The progress notes revealed:</p> <ul style="list-style-type: none"> a. 7/10/21 at 2:51 PM, focused evaluation - the resident exited the facility through the kitchen and went out back. The resident brought back inside the facility and head to toe assessment completed with vital signs. b. 7/10/21 at 3:16 PM, focused evaluation - the resident continued to exit seek and roamed this shift. Redirection and distractions effective this shift. c. 7/10/21 at 6:24 PM, nurse's note - the resident found outside, another resident witnessed him go through the kitchen through the back door. The resident was brought back into the facility. d. 7/10/21 at 6:30 PM, nurse's note - this nurse notified by another resident, observed the 			
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	<p>resident go to the kitchen and minutes later observed the resident outside. The CNA's immediately went out and the resident returned to the facility. This nurse took vitals and head to toe assessment completed. The resident denied pain. The resident alert confused to place, time and day. No injuries noted. Full range of motion to all extremities. The resident noted to be incontinent and the CNA's assisted the resident with cares. The MDS nurse and Administrator notified.</p> <p>e. 7/10/21 at 7:52 PM, nurse's note - the resident's power of attorney notified and voiced no concerns.</p> <p>f. 7/11/21 at 3:55 AM, focused evaluation - the resident up in wheelchair at 3:15 AM, one to one care. The resident brought to the nurses station for observation.</p> <p>The facility incident report titled Elopement dated 7/10/21 at 6:20 PM, indicated the incident occurred outside; the resident seen going into the kitchen and staff went to the kitchen and the resident out the door. Immediate action taken: placed one to one immediately. No injuries observed at the time of the incident. No witnesses found.</p> <p>Observations of Resident #1 on 7/12/21 at:</p> <p>a. 3:45 PM, lying in bed, facing the wall, and blankets in place. The resident's wheelchair</p>			
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	<p>beside the bed. Staff E CNA in the resident room providing one to one.</p> <p>b. 4:37 PM, the resident continued to be lying in bed with Staff E CNA providing one to one.</p> <p>c. 5:25 PM, sat in wheelchair at the dining room table, Staff E CNA providing one to one. The wander guard transmitter on the wheelchair.</p> <p>d. 5:50 PM, propelled self in wheelchair, Staff E CNA providing one to one.</p> <p>e. 6:18 PM, sat in wheelchair in room with Staff E CNA providing one to one.</p> <p>Observations of Resident #1 on 7/13/21 at:</p> <p>a. 7:55 AM, sat in wheelchair at the dining room table, conversed pleasantly with tablemates. Staff N CNA sat with the resident, provided one to one.</p> <p>b. 9:21 AM, continued to be at dining room table in wheelchair, head down and eyes closed. Staff N CNA sat with the resident, providing one to one.</p> <p>c. 12:36 PM, sat at the dining room table in wheelchair, Staff N CNA sat with the resident.</p> <p>d. 4:25 PM, rested in bed with facility staff present</p> <p>Observations Resident #1 on 7/14/21 at:</p>			
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	<p>a. 7:59 AM, sat the dining room table with fellow residents and Staff N CNA sat with the resident.</p> <p>b. 10:00 AM, lying in bed with eyes closed, Staff N CNA sat with the resident</p> <p>c. 11:53 AM, sat in wheelchair at the dining room table, Staff N CNA sat with the resident</p> <p>Observation on 7/12/21 at 5:30 PM, the surveyor observed the kitchen area where the resident entered and exited the facility via his wheelchair on 7/10/21, related to the location of where staff observed him outside of the facility. The observation showed the resident went through the dishwashing area, turned left down a hall and exited the rear service door. The distance the resident traveled from entering the kitchen to the sidewalk by the laundry house approximately 68-80 steps.</p> <p>On 7/12/21 at 3:25 PM, the Regional Director of Operations stated a resident alerted facility staff that Resident #1 went into the kitchen. The Director stated a CNA went into the kitchen to locate the resident and could not locate him in the kitchen. The CNA returned to the dining room and dietary staff observed the resident through the dining room window on the sidewalk. The Director stated the facility implemented a combination of one to one's, frequent checks, and video</p>			
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	<p>monitoring. The Director stated staff would place the resident in the nurse's station when no staff available and they would always lock the kitchen doors unless staff serving a meal at meal time. The Director stated the facility continued to work on placement in a locked unit for the resident.</p> <p>On 7/12/21 at 3:35 PM, the Administrator stated the facility staff constantly observed Resident #1 between one to ones and video monitoring. The Administrator stated if the resident is not in his room or one to one, that staff would have him in the nurses station circle or a table by the nurse's station. The Administrator stated facility staff reviewed additional interventions for the resident.</p> <p>On 7/12/21 at 4:20 PM, Staff L Dietary Aide confirmed he worked on the evening of 7/10/21. Staff L stated at the time of the incident on 7/10/21, 2 dietary staff worked behind the serving counter and Staff L worked in the prep area, 1st door to the left of the serving counter. Staff L stated he did not see Resident #1 approach the kitchen doors and did not know the resident went outside. Staff L identified the prep door as open during meal service. Staff L stated the door to the right of the serving counter not open at that time and not able to view soiled cart door.</p>			
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	<p>On 7/12/21 at 4:29 PM, the Staff M Dietary Aide confirmed she worked the evening of 7/10/21. Staff M stated the resident roamed around and hard to keep an eye on him. Staff M stated she served desserts at the time of the incident, behind the service counter, and did not observe anything. Staff M stated she did not see Resident #1 approach the kitchen doors. Staff M stated unsure of when she last saw the resident.</p> <p>On 7/12/21 at 4:37 PM, Staff E CNA confirmed she worked on the evening of 7/10/21. Staff E stated she worked the 600 hall and busy before and after supper. Staff E stated she saw Resident #1 at supper, while he ate at the dining room table. Staff E stated she arrived in the dining room and observed Staff F CNA assisting Resident #1 into the facility through the north dining room door. Staff E stated she did not see anything and heard a fellow resident observed Resident #1 go into the kitchen.</p> <p>On 7/12/21 at 4:44 PM, Resident #10 (BIMS 15, no cognitive impairment) stated on 7/10/21, she observed Resident #1 propel himself in his wheelchair down the 300 hall and staff stopped him. Resident #10 stated she observed Resident #1 enter the kitchen through the soiled cart door (to the far south of the serving counter). Resident #1 stated she hollered out for staff to alert them</p>			
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	<p>that Resident #1 entered the kitchen. Resident #10 stated Staff F CNA entered the kitchen, however, returned stating the resident was not in the kitchen. Resident #10 stated at that time, she observed Resident #1 outside the north dining room window, in his wheelchair, on the sidewalk. Resident #10 stated there were 5 facility staff at the serving counter in the dining room when Resident #1 entered the kitchen, waiting for the Dietary cook to prepare trays. Resident #10 stated the facility staff were too busy chit chatting when Resident #1 entered the kitchen. Resident #10 identified the soiled cart door to the kitchen as always open at meal time due to staff taking dirty trays in. Resident #10 stated dinner completed at the time the incident occurred at approximately 6:00 PM.</p> <p>On 7/12/21 at 5:35 PM the Dietary Manager stated prior to the incident on 7/10/21, staff were directed to keep the doors into the kitchen shut. The Dietary manager identified staff go in and out of the soiled cart door so difficult to have it closed. The Dietary Manager stated the door would be open if the dietary staff were present doing dishes. The Dietary Manager identified difficulty and the need to be careful due to Resident #1.</p>			
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Facility Administrator

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	<p>On 7/12/21 at 5:48 PM, Staff B CNA stated the soiled cart door leading into the kitchen is propped open after dinner when the dietary staff do dishes, and identified this in place prior to the incident on 7/10/21.</p> <p>On 7/13/21 at 8:07 AM, Staff O RN confirmed she worked on the evening on 7/10/21. Staff O stated she brought the medication cart up from the 500 hall and heard Resident #10 holler about Resident #1 outside. Staff O identified the resident as already outside when she arrived. Staff O stated when Resident #1 returned inside the facility, she completed a head to toe assessment. Staff O stated she did not recall what the resident wore at the time of the incident, however, the resident was incontinent of urine and the CNA's provided cares. Staff O denied the resident had injuries or bruising at time of the assessment and no sweating observed. Staff O identified the doors leading into the kitchen all propped open that evening and she shut them after the resident returned into the facility. Staff O stated the dietary staff prop open the doors at meal time.</p> <p>On 7/13/21 at 8:31 AM, Staff P RN stated on the overnight shift 7/11/21, staff sat with Resident #1 one to one.</p>			
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	<p>On 7/13/21 at 9:14 AM, the Dietary Manager stated the dietary staff propped open the entrance doors to the kitchen at meal time, however, staff were to be present. The Dietary Manager stated they are no longer propping open the kitchen doors.</p> <p>On 7/13/21 at 9:18 AM, Resident #11 (BIMS 13, no cognitive impairment) stated there were times the kitchen doors were propped open at meal time and unsure if any staff present at the time.</p> <p>On 7/13/21 at 10:18 AM, the Temporary Maintenance man stated he would place a key pad lock on the back kitchen door leading out to the vestibule area.</p> <p>On 7/13/21 at 10:57 AM, the State Climatologist reported the temperature on 7/10/21 at 6:00 PM, 66 degrees with northeast winds at 15 mph and gusts of 22 mph. The state climatologist reported light to moderate rain from 5:45 PM - 7:45 PM.</p> <p>On 7/13/21 at 11:59 AM, the Regional Director of Operations stated no alarm would be placed on the back service door due to the wiring. The Director stated the Temporary Maintenance man would install a key pad lock to the vestibule door and to the door leading into the prep area of the kitchen.</p>			
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	<p>On 7/13/21 at 12:40 PM, Staff Q Dietary Cook confirmed she worked the evening on 7/10/21. Staff Q stated when Resident #1 entered the kitchen, she was located behind the serving counter and did not observe him approaching. Staff Q stated all 3 doors leading into the kitchen were propped open at the time, along with the 2 service doors at the back of the kitchen. Staff Q stated the dietary staff go in and out with garbage and if the door was not propped open they would get locked out of the kitchen. Staff Q stated the dietary staff attempt to finish up and leave, so they prop the doors open. Staff Q stated all 3 doors leading into the kitchen now have to remain closed at this time. Staff Q identified the 1st back service door key lock pad placed. Staff Q stated staff observed Resident #1 in the kitchen previously while the dietary staff present and they re-directed the resident. Staff Q stated last she observed Resident #1 on 7/10/21, he ate at the dining room table. Staff Q identified the weather as raining at the time the resident outside. Staff Q did not know what the resident wore when he left.</p> <p>On 7/13/21 at 2:21 PM, Staff T CNA confirmed she worked the evening on 7/10/21. Staff T stated unsure of the time she saw Resident #1 on 7/10/21. The resident propelled himself in his wheelchair between 300 and 500 halls close to</p>			
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	<p>the nurse's station. Staff T identified the kitchen doors as usually wide open during meal service due to the traffic in and out, however, did not recall if the doors open at the time of the incident.</p> <p>On 7/13/21 at 2:35 PM, Staff R RN confirmed she worked the evening of 7/10/21. Staff R stated Resident #1 sat at the dining room table the last time she saw him. Staff R stated she Resident #1 went outside through the kitchen doors. Staff R stated the doors leading into the kitchen propped open during meal service. Staff R stated previously in the day Resident #1 attempted to exit the facility through exit in 100 hall, however, staff re-directed him.</p> <p>On 7/13/21 at 3:04 PM, Staff F CNA confirmed she worked the evening of 7/10/21. Staff F identified room trays delivered and standing at the service counter. Staff F stated Resident #10 informed her Resident #1 entered the kitchen in his wheelchair. Staff F stated she entered the kitchen through the soiled cart door and proceeded to check the 3 storage rooms, the section of the kitchen where the stove located, and the dry storage room and could not locate the resident in the kitchen and returned to the dining room and then observed the resident outside on the sidewalk. Staff F identified Resident #1 as close to the white gate that leads to the laundry</p>			
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	<p>house. Staff F stated herself and a dietary aide assisted the resident back into the facility. Staff F stated the resident wore a short sleeve shirt and shorts. The temperature felt chilly outside. Staff F did not observe any injuries when the resident returned inside the facility. Staff F did not observe the resident going towards the kitchen doors or enter into the kitchen. Staff F observed the resident get his dinner at 5:15 PM, looked in the kitchen at 6:00 PM, and at 6:10 or 6:15 PM, assisted the resident back into the facility.</p> <p>On 7/13/21 at 3:15 PM, Staff S CNA confirmed she worked the evening of 7/10/21. Staff S identified the last time she observed Resident #1 as during passing trays. Staff S could not recall what the resident was doing. Staff S stated she assisted residents in the assisted dining room and did not know the resident entered the kitchen or exited the facility.</p> <p>On 7/13/21 at 11:36 AM, the Regional Director of Operations stated prior to the incident with Resident #1 on 7/10/21, the common practice was to leave the doors leading into the kitchen open during the meal service. The Director identified the new practice put into place as: the doors no longer open and key lock pads placed. The Director stated if the back kitchen service doors were open at the time of the incident, she</p>			
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	<p>would expect staff to close them. The Director stated she did not know if the dietary staff were required to be in the dishwashing area if the soiled cart door opened, however, the dietary staff were in the proximity.</p> <p>Immediate Jeopardy Removal:</p> <p>The facility removed the initial immediate jeopardy on 7/1/21 when they educated staff on the timely abuse reporting, elopement prevention, missing resident, missing resident prevention, door alarms specific to the facility, and increased the door and wander guard alarm checks. However, a second immediate jeopardy occurred on 7/10/21 and removed on that same day when the facility implemented one to one's &/or continuous checks with the resident, and staff education related to the supervision of the resident and the kitchen doors remaining closed. Scope and severity lowered to G level due to Resident #4's fall that resulted in a fracture. The facility was notified of the initial immediate jeopardy on 7/1/21.</p> <p>2. The MDS for Resident #4, with a completion date of 5/3/21, identified a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. The MDS</p>			
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	<p>revealed the resident independent with transfers and ambulation. The MDS revealed the resident required supervision with physical assist of one staff for locomotion on the unit (how the resident moves between locations in room and adjacent corridor on the same floor). The MDS documented diagnosis of hypertension, diabetes, abnormal gait & mobility, and anxiety.</p> <p>The Care Plan with initiation date of 2/19/21, identified the resident independent with ambulation and transfers with use of assistive device.</p> <p>The care plan with initiation date of 2/19/21, identified the resident had history of falling. The care plan directed staff to: assist with one staff for all ambulation (1/24/21), encourage to wear tennis shoes when not in room (6/24/21), prefer to wear tennis shoes (6/24/21), keep walker within reach at all times (1/24/21), monitor for changes in condition that may warrant increase supervision/assistance & notify physician (1/24/21), remind me to ask for assist for all ambulation (1/24/21).</p> <p>Fall risk evaluation dated 4/13/21, scored the resident a 4 due to current medications. Total score of 10 or above represents a high risk for falls.</p>			
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	<p>The progress notes revealed:</p> <p>a. 6/23/21 at 5:40 PM, nurse's note - after witnessed fall in the hallway, the resident complained of left ankle pain. Ankle distortion noted and call placed to the resident's primary care provider, order received to send to local emergency room (ER) for evaluation.</p> <p>b. 6/23/21 at 5:41 PM, nurse's note - the resident out to the ER per facility van</p> <p>c. 6/23/21 at 6:58 PM, incident, accident, unusual occurrence note - the nurse called to the hallway by CNA, the resident sat on buttocks on the floor leaning on left arm. The resident had walker in front of him, non-skid socks on and no shoes. The flooring in the hallway in process of replacement, part of the floor bare and other part new wood. The resident informed the nurse his foot got stuck in the glue and he fell. The resident identified little pain in left leg. Staff completed an assessment and the resident able to move all extremities. The resident assisted with 2 staff and gait belt to transfer into the wheelchair. The resident to the dining room and complained of increased pain to left ankle. Visual assessment noted ankle distorted. Call placed to the resident's primary care provider and order received to send to the local ER (emergency room) for evaluation.</p> <p>d. 6/23/21 at 10:17 PM, nurse's note - call received from the ER, the resident admitted due to ankle fracture.</p>			
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	<p>e. 6/26/21 at 11:03 AM, nurse's note - called local hospital and reported the resident is non-weight bearing on affected leg.</p> <p>f. 7/1/21 at 12:58 PM, admit/re-admit - resident alert and orientated to person, place, time, and situation. The resident functional status: transfer and ambulation with assist of 2 and non-weight bearing</p> <p>Facility Incident report titled Witnessed fall dated 6/23/21 at 5:00 PM, identified the incident location in the hallway. Incident description: the nurse called to the hallway by the CNA and noted the resident on buttocks on the floor, leaning on left arm. The resident had the walker in front of him, non-skid socks on, and no shoes. The flooring in the hallway being replaced with part of the floor bare and part new wood. The resident stated his foot got stuck in the glue and he fell. The resident stated little pain in left leg. Immediate action taken: assessment completed and the resident able to move all extremities. Assisted the resident to transfer to the wheelchair with 2 staff and gait belt. The resident taken to the dining room for his meal. Injuries observed at time of incident: no injuries observed at time of the incident. Level of Pain: 2 out of 10. The resident alert and ambulatory without assistance. Mental Status: orientated to person, place, situation, and time. Note: the resident transported</p>			
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	<p>to the ER, left ankle fracture. Injuries report post incident: left ankle fracture. Predisposing environmental factors: noise and "other". Predisposing physiological factors: gait imbalance. Predisposing situation factors: using walker and ambulating without assistance. Other: exposed glue from flooring replacement.</p> <p>ER X-ray report dated 6/23/21 at 7:30 PM, identified a displaced transversely oriented medial malleolus and distal fibular obliquely oriented fracture, the latter of which exhibits some comminution; presumed avulsed fracture fragments off the medial distal tibial upon; medial subluxation of the tibia upon the talar dome with abnormal clockwise rotation (left ankle fracture).</p> <p>Hospital form titled History and Physical dated 6/23/21 at 11:09 PM, noted the resident presented to the ER for complaints of left ankle pain following a fall. In the ER labs included red blood cells (RBC) 3.07 (normal 4.2-6.2) and hemoglobin (Hgb) 9.4 (normal 12-18). The resident stated he tried to walk to get to evening meal and work in progress on floors, and he tripped. Physical exam revealed left ankle swelling and tenderness.</p> <p>Hospital form titled Nephrology Consult dated 6/30/21 at 10:32 AM, chief complaint chronic</p>			
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	<p>kidney disease; acute kidney injury with worsening anemia. The resident's hemoglobin progressively going down. The resident would benefit from intravenous iron and Procrit (used to treat anemia). Lab review:</p> <ul style="list-style-type: none"> a. Red blood cells (normal 3.07) - 6/28/21 2.76; 6/29 2.27; and 6/30 2.35 b. Hemoglobin (normal 12-18) - 6/28 8.6; 6/29 7.0, and 6/30 7.0 c. Hematocrit (normal 42-54) - 6/28 26.9; 6/29 22.0, and 6/30 22.2 <p>Plan: from renal standpoint recommend Procrit and iron today. Monitor hemoglobin and transfuse if hemoglobin goes below 7. Hemoglobin needs to be improved, above 8 before safe discharge. Recommend outpatient iron infusions for 5 weeks.</p> <p>Hospital form titled Clinical Transfer Report with admission date of 6/23/21, identified the resident received the following additional medications while hospitalized:</p> <ul style="list-style-type: none"> a. Hydrocodone/acetaminophen (narcotic) 5/325mg - orally 6/27/21 b. Morphine (narcotic) 2mg - injection on 6/24/21 c. Acetaminophen (analgesic) 650mg - orally on 6/25/21 d. Oxycodone/acetaminophen (narcotic) 5/325mg - 2 tablets orally 6/29/21 			
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	<p>e. Demerol (narcotic) 50mg - injection 6/24/21</p> <p>f. Iron sucrose 100mg - intravenously 6/23/21, 6/30/21, and 7/1/21</p> <p>g. Retacrit/Procrit - injection 6/30/21</p> <p>Labs included for 7/1/21: red blood cells 2.48, hemoglobin 7.6, and hematocrit 23.6</p> <p>Hospital form titled Daily Progress Note dated 6/27/21, identified principal problem anemia. Hemoglobin in the past ranged between 8-9, with current hemoglobin of 7. The resident placed black on iron supplement, and a blood transfusion recommended, however, the resident refused for religious reasons. Labs reviewed: Hemoglobin on 6/25/21 7.9; on 6/26 7.2 and on 6/27 7.0.</p> <p>Observations:</p> <p>a. 6/29/21 at 3:51 PM, hall 500 revealed no flooring, bare concrete present. Halls 500 and 300 only 2 with bare concrete floors at this time. Orange cones with yellow caution tape in place around the edge of the dining room.</p> <p>b. 6/30/21 at 4:20 PM, halls 300 & 500 both into the main dining area continue to have bare concrete floors. No glue remnants and no areas noted to be sticky. The edges of the new flooring from the dining room and the nurse's station taped down with blue tape. Orange cones with</p>			
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	<p>yellow caution tape in place around the edge of the dining room continue to be in place.</p> <p>c. 6/30/21 at 6:30 PM, the flooring crew installing the new flooring at this time</p> <p>d. 7/1/21 at 7:45 AM, the flooring in halls 300 & 500 completed.</p> <p>e. 7/6/21 at 12:16 PM, Resident #4 in wheelchair in the main dining room, well groomed. Cast with ace wrap present to left foot and non-skid sock to the right foot.</p> <p>f. 7/7/21 at 10:15 AM, Resident #4 in wheelchair in his room. Cast in place to left lower leg and non-skid sock to right foot. The resident well-groomed and call light in reach.</p> <p>On 7/6/21 at 2:33 PM, the Resident #4 (non-interviewable) identified he was recently hospitalized due to fractured left foot. Resident #4 stated he headed out to supper with his walker and the flooring crew worked on the floors in the hallway. The resident stated had socks on, and he tripped on something. Resident #4 stated no facility staff present at the time of the fall, and facility staff did not inform him to wait for assistance due to the active construction. Resident #4 stated new flooring on ½ of the hall, however, bare concrete floor in front his doorway. The resident stated prior to the fall, he ambulated independently with a walker, and now requires assist with everything for 6 weeks. The resident</p>			
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	<p>identified pain in ankle at times, however, pain medication available as needed.</p> <p>On 7/6/21 at 2:41 PM, Staff D LPN stated she worked on the evening on 6/23/21, when Resident #4 fell. Staff D stated the flooring crew placed the new flooring on the opposite side of the hall from the resident's door and asked the facility staff to get the residents out of their rooms so they could proceed to the other half of the hall. Staff D stated the CNA's told Resident #4 to come out of his room to the dining room for supper. Staff D stated when the resident came out with his walker and non-skid socks, per usual, his foot got stuck in the glue. Staff D stated Staff Y CNA requested assistance, as Resident #4 on the floor. Staff D stated the resident complained of minimal pain to left foot. Staff D stated the resident able to move all extremities and transferred the resident to the wheelchair. Staff D stated Resident #4 complained of increased pain to left lower leg approximately 10 minutes later while at the dining room table. Staff D stated she noted the resident had deformed left ankle and had requested the MDS nurse assess the area. Staff D stated Resident #4 ate supper and then the facility van transported him to the local ER. Staff D stated floor in front of Resident #4's doorway contained bare concrete and the opposite side of the hall had new flooring with a</p>			
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	<p>strip of glue showing. Staff D did not know the resident was asked to wait for assistance before leaving his room. Staff D stated staff would remind him of when to eat and he would independently ambulate to the dining room. Staff D stated the residents knew of the men working on the floors. Staff D stated she did not feel there was a problem with the residents being up independently in the halls. Staff D stated after the incident the facility changed the time for the work to be completed to later in the evening. Staff D stated there were no warning cones or yellow tape in place to alert anyone of hazards until after the incident on 6/23/21.</p> <p>On 7/6/21 at 2:54 PM, Staff Y CNA confirmed she worked the evening of 6/23/21. Staff Y stated the flooring crew worked on ½ of the hall leaving fresh glue, sticky and tacky, exposed. Staff Y stated Staff D LPN requested staff assist the residents out to the dining room. Staff Y stated she assisted two other residents and ½ back down the hall she observed Resident #4 come out of his room and step in the glue with his sock. Staff Y stated Resident #4's sock stuck in the glue and when he attempted to lift his foot, he lost his balance and fell backwards. Staff Y stated she sat with the resident until Staff D LPN arrived to assess him. Staff Y stated the resident complained of left ankle pain. Staff Y stated staff</p>			
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Facility Administrator

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Citation**

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	<p>assisted the resident to the wheelchair and took him to the dining room to eat prior to his going to the local ER. Staff Y identified the exposed glue as hazardous for the residents who ambulated independently. Staff Y stated she did not requested Resident #4 wait for assistance and the resident came out for supper per usual. Staff Y identified no orange cones or yellow caution tape in place when the incident occurred. Staff Y identified signs posted at front door and at the nurses station regarding the new flooring process.</p> <p>On 7/6/21 at 5:20 PM, the Regional Director of Operations stated she was at the facility when Resident #4 fell on 6/23/21. The Director stated the flooring crew actively worked on replacing the flooring when Resident #4 fell. The Director identified signs posted at the front entrance and at the nurses station regarding floor replacements. The Director stated Resident #4 stepped into the glue and got his sock stuck. The Director stated not sure what else they could have done to prevent the fall. The Director stated she did not know if the floor replacement area contained orange cones or yellow caution tape at the time of the fall to alert residents of hazards.</p> <p>On 7/6/21 at 5:33 PM, Staff Z CNA confirmed she worked on the evening of 6/23/21. Staff Z stated</p>			
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	<p>there were no orange caution or yellow caution tape in place at time of the fall. Staff Z identified new flooring in ½ of the 600 hall with exposed glue present.</p> <p>On 7/6/21 at 5:36 PM, the Administrator stated signs were posted regarding the floor replacement with a schedule at the front door of the facility and the 4 sides of the nurses station, and the pillars leading into the dining room. The Administrator stated prior to the replacement of the flooring the managers, nurses, and CNA's meet to discuss best time to work on the replacement, reviewing pros and cons of during the day or evening.</p> <p>On 7/6/21 at 5:53 PM, Staff E CNA confirmed she worked on the evening shift of 6/23/21. Staff E stated she did not see the resident fall. Staff E identified the hall flooring as ripped up and ½ replaced with 2 inches of glue exposed. Staff E stated she did not recall orange cones or yellow caution tape in place at the time of the fall, or work in progress signs. Staff E stated signs posted at the nurses station informed residents of the dates and approximate times each hall would be worked on. Staff E stated after Resident #4 fell, the flooring workers came later.</p>			
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	<p>On 7/8/21 at 10:13 AM, the Administrator stated she thought interventions were in place at the time of the fall and the facility had good communication with the flooring company and the facility staff. The Administrator stated the flooring company had additional staff in the facility during the replacement of the flooring. The Administrator identified the resident's safety as ultimately the facility's responsibility. The Administrator revealed Resident #4 as independent with ambulation and facility staff felt the resident did not need assistance during the time of the flooring replacement in the resident's hallway. The Administrator stated hindsight suggested staff would place any resident leaving their room in a wheelchair.</p> <p>FACILITY RESPONSE:</p>			
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50.7(4)	481—50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(4) When a resident elopes from a facility. For the purposes of this subrule, "elopes" means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff. DESCRIPTION:	II	\$500 (Held In Suspension)	Upon Receipt

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	<p>Based on observation, record and policy review, and staff interview the facility failed to investigate and report a cognitively impaired resident elope from the facility without staff knowledge to the Iowa Department of Inspections and Appeals (DIA) within 24 hours for 1 of 1 resident reviewed (Resident #1). Facility policy did not contain a directive to notify DIA. Facility census was 77 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) for Resident #1 with a completion date of 6/22/21, identified a Brief Interview for Mental Status (BIMS) score of 1 (severe cognitive impairment and decision making skills). The MDS documented the resident exhibited wandering on 1-3 days of the 7 day look back period. The resident required limited assistance of 1 staff for transfers, and supervision with 1 person physical assistance for locomotion on and off the unit. The MDS documented diagnosis of Non Alzheimer's Dementia and anxiety. The resident admitted to the facility 6/8/21.</p> <p>The Care Plan with initiation date of 6/14/21, identified the resident at risk for elopement &/or wandering related to history of attempts to leave the facility unattended and wandering aimlessly.</p>			
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	<p>The care plan interventions included: alert staff to wandering behavior (6/14/21); if wander away from the unit, staff stay with the resident (6/14/21), converse and gently persuade the resident to walk back to the designated area (6/14/21); note which exits are favored for elopement from the facility and alert staff working in those areas (6/14/21); monitoring device placed that sounds alarm when leaving the building; provide diversional activities (6/14/21); and assign staff to account for my whereabouts throughout the day, one to one (7/12/21). The care plan with initiation date of 6/10/21, identified the resident enjoyed reading, food activities, listening to country music, being around animals, watching the television, and being outside.</p> <p>The progress notes revealed:</p> <p>a. 6/23/21 at 2:57 PM, focused evaluation - the resident asked the nurse to take him home after lunch, easily re-directed.</p> <p>b. 6/27/21 at 2:18 AM, focused evaluation - the resident had no exit seeking behaviors.</p> <p>c. 6/28/21 at 1:52 AM, focused evaluation - the resident exit seeking 2 times, out the 600 & 700 hall doors with the wander guard alarm sounding. The resident sat at the nurse's station and offered snack. The resident toileted and assisted to bed at 1:45 AM.</p>			
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	<p>d. 6/28/21 at 2:17 PM, focused evaluation - the resident continued to be exit seeking. The resident goes to several halls at different times, opened doors and exits facility. The resident not easily re-directed and upset with staff.</p> <p>The progress notes revealed no documentation that Resident #1 left the facility without staff knowledge (eloped) or of an assessment of the resident upon the return to the facility following an elopement on 6/27/21.</p> <p>The facility document titled Missing Resident revised 12/7/09, stated the facility would maintain a list of residents identified at risk for exit seeking. The list will be kept at the Nurses station and include the resident's picture and pertinent information on each resident listed. Upon notification that a resident missing:</p> <ul style="list-style-type: none"> a. If off duty hours, notify the Administrator and Director of Nursing (DON) b. Assemble all available department heads c. Organize and institute a thorough search of the facility d. If a search of the facility and grounds failed to locate the missing resident, notify the next of kin e. Notify local law enforcement f. Recall off duty personnel as needed 			
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	<p>g. Notify the Divisional Director and the Nurse Consultant</p> <p>h. Notify the Director of Safety</p> <p>Observation on 6/30/21 at 1:20 PM, by the surveyor of the area where the resident was found in his wheelchair on 6/27/21 related to the location of the facility. The observation showed the resident crossed the street, went downhill, and ended up located at an incline in the driveway with 3 cars present. The distance the resident traveled from the facility could vary from 159 - 175 steps depending on the door he exited the facility from. It took the surveyor approximately 3 minutes to continuously walk the distance without any stops.</p> <p>On 6/29/21 at 4:26 PM, Staff E Certified Nurse's Aide (CNA) stated she headed into the facility on 6/27/21, for her scheduled shift at 2:00 PM and observed Resident #1 in his wheelchair, 3-4 houses down the hill from the facility. Staff E stated Resident #1 went across the street, down the hill, and sat in a driveway. Staff E stated she went to the resident as he sat next to the sloped section of the driveway. She observed the resident wore slacks, short sleeve shirt, hat, and glasses. Staff E stated Resident #1 told her he could not get up the hill. Staff E identified the weather as "hot" on 6/27/21. Staff E stated she</p>			
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	<p>did not observe any injuries, bruising or bleeding to Resident #1. Staff E stated Resident #1 had a history of exit seeking and setting off the alarms. Staff E confirmed Resident #1 had a wander guard transmitter in place on the wheelchair. Staff E stated when Resident #1 returned to the facility, staff did not know he was missing. Staff E stated when Staff F CNA arrived at the facility for her scheduled shift on 6/27/21, Staff F observed the resident being assisted up the hill back to the facility, and inquired what occurred. Staff E stated an agency nurse also arrived for her scheduled shift at that time and observed the resident being returned to the facility. Staff E stated she took Resident #1 into the facility through the front doors and entered the door alarm code when she entered. The wander guard alarm did sound upon entrance. Staff E stated she took Resident #1 to the nurse's station and notified Staff G LPN (licensed practical nurse) that she found the resident outside and down the hill from the facility without staff with him. Staff E stated she did not know if Staff G LPN completed an assessment of Resident #1. Staff E stated it was the weekend and no administrative staff worked so she placed a note under the Administrator's door of the incident. She did not receive call from the facility regarding the incident. Staff E stated Resident #1 had a history of exit seeking behaviors, and got to the door previously but staff intervened. Staff E</p>			
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	<p>stated the facility did not provide any education after the 6/27/21 incident with Resident #1. Staff E stated she did not know what door Resident #1 exited from and the resident would not be able to confirm what door he exited. Staff E identified concerns for Resident #1's safety due to the potential of rolling into the street &/or tipping out of his wheelchair. Staff E stated she informed Staff G LPN that she left a note for the Administrator regarding the incident.</p> <p>On 6/30/21 at 9:26 AM, Staff G LPN confirmed she worked the day shift on Sunday 6/27/21. Staff G stated Resident #1 frequently tried to leave the facility and stated the resident set the alarms off and staff would respond. Staff G stated Resident #1 attempted to leave the facility earlier in the day, before noon, on 6/27/21. Staff G stated the door alarm and the wander guard alarm sounded, she responded and Resident #1 did not get outside. Staff G denied staff reported to her that they found Resident #1 outside unattended on 6/27/21. Staff G denied Resident #1 ever outside the facility unattended or off the facility grounds. Staff G stated she was not aware of Resident #1 off the facility grounds on 6/27/21 and denied any CNA reported this to her.</p> <p>On 6/30/21 at 10:24 AM, the Regional Director of Clinical Services stated the facility did not have</p>			
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	<p>cameras inside the facility or outside on the facility grounds. The Regional Director of Clinical Services stated the facility needed to complete a self-report regarding the 6/27/21 elopement. The Regional Director of Clinical Services stated Staff E CNA left a note for the Administrator on Sunday 6/27/21, regarding an elopement. The Regional Director of Clinical Services stated the Administrator observed 3 notes when she arrived at work on Monday 6/28/21, however, had not read the notes until today 6/30/21. The Regional Director of Clinical Services stated they were conducting interviews, working on staff education, and the charge nurse in question suspended until investigated. The Regional Director of Clinical Services stated Staff G LPN informed her she did not recall anyone informing her of Resident #1 found outside. The Regional Director of Clinical Services identified the facility in process of notifying Resident #1's primary care provider, family, and on line report to DIA.</p> <p>On 6/30/21 at 1:04 PM, Staff F CNA stated when she arrived to her scheduled 2:00 PM shift on 6/27/21, she observed Staff E CNA propelling Resident #1 up the hill back to the facility. Staff F stated she asked Staff E what occurred and Staff E informed her Resident #1 had been down the hill in a driveway across the street. Staff F stated the 2 CNA's assisted the resident inside the</p>			
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	<p>facility and took him to the nurse's station and staff had no knowledge the resident had gone outside. Staff F stated she informed Staff G LPN Resident #1 went outside and Staff G responded "okay". Staff F stated to silence the alarms, staff on duty at the time would have to go to the door to shut off the alarm, and staff waited too long to shut off and then did not observe Resident #1 outside. Staff F stated the CNA's on duty at the time did not know the resident was missing. Staff F stated Resident #1 appeared he was outside for a while and was sweating. Staff F stated the resident wore pants and long sleeve shirt.</p> <p>On 6/30/21 at 2:32 PM, the Administrator stated she had been employed at the facility for short time and when she arrives at work will have notes under her door. The Administrator stated notes are requests to visit with certain residents. The Administrator stated this week she tried to get staffing filled and pushed the notes to the side on Monday 6/28/21 and did not read them. The Administrator stated she read the notes today (6/30/21) and read the note regarding Resident #1 found outside the facility on 6/27/21 by staff who arrived to work for their scheduled shift at 2:00 PM.</p> <p>On 7/8/21 at 10:13 AM, the Administrator stated she expected facility staff to call herself &/or the</p>			
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	<p>Director of Nursing (DON) when staff found Resident #1 outside the facility unattended on 6/27/21. The Administrator stated she expected the nurse to complete an assessment after the nurse determined the resident safe. The Administrator stated she expected staff to notify the resident's family and primary care provider of the elopement. The Administrator stated she would have filed a report with DIA within 24 hours of the elopement and within 2 hours, if the resident received an injury. The Administrator stated once the resident safe; determine what happened, obtain staff statements, and put interventions in place to prevent.</p> <p>FACILITY RESPONSE:</p>			
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