STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING KC on 1/14/16	C 12/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 1/8/16 Complaints # 56057-C and # 56129-C were substantiated. Investigation of facility-reported incidents #56504-I and #56840-I resulted in deficiency. See Code of Federal Regulation, (42CFR Part 483, Subpart B-C)	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/08/2016

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.

POC accepted 1/14/16 KC

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F 279	Continued From page 1 Based on clinical record review and staff interview, the facility failed to update a care plan to reflect a resident's current care status for 1 resident (Resident #9) of 12 residents selected for review. The facility identified a census of 98 residents. Findings included: According to a Minimum Data Set (MDS) assessment with dated 11/29/15, Resident #9's diagnoses included: Non-Alzheimer's dementia, psychotic disorder, depression and diabetes mellitus. The MDS identified the resident with long and short term memory problems and modified independence with cognitive skills for daily decision-making. The MDS revealed the resident sometimes understood others and sometimes had the ability to make him/herself understood. The assessment documented no wandering behavior during the assessment period and the resident walked independently without assistive devices. The MDS identified the resident entered the facility on 2/2/07. The resident's current care plan, identified the resident spoke little English due to his/her nationality, as being unable to use a communication board due to dementia progression and s/he sometimes made poor safety choices. The care plan included a goal to not harm him/herself or others with a date initiated date of 9/9/13 and an intervention (date initiated 5/20/15) for Resident #9 to wear a Wandergaurd bracelet (electronic device that signals an alarm on a exit door) on the resident's leg The same intervention identified the Wandergaurd as resolved on 11/27/15.	F 279		

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F 279	Continued From page 2 Review of the resident's pocket care card (updated as needed by nursing staff to reflect the daily care required by a resident), dated 12/2/15, included an approach for "FREQUENT CHECKS". Review Resident #9's Progress Notes included the following documentation: a. On 5/18/15 (no time) nursing staff found the resident wandering in the halls and staff placed a Wandergaurd on the resident's left wrist. b. On 7/23/15 at 4:05 A.M., (as noted above), nursing staff found the resident walking in a back employee hallway and applied a Wandergaurd. (Note: the resident's progress notes and care plan, lacked documentation as to when staff discontinued the resident's Wandergaurd after placed on 5/18/15. The care plan lacked documentation in regards to the Wandergaurd being placed back on the resident on 7/23/15). c. On 7/24/15 at 10:39 P.M., nursing staff documented the resident removed his/her Wandergaurd from his/her left ankle. The resident's son/daughter found 2 Wandergaurd bracelets under the resident's bed and the facility had no other Wandergaurd bracelets. Staff implemented 15 minute checks. (Note: the care plan lacked reference to the resident's refusal to leave the Wandergaurd on and/or the implementation of the 15 minute checks). d. On 8/5/15 at 6:08 P.M., nursing staff documented the resident's 15 minute checks as discontinued and the Wandergaurd remained off the resident. (The care plan lacked reference to the resident's 15 minute checks being	F 279		

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F 279	Continued From page 3 discontinued and no further use of a Wandergaurd. As noted above, the care plan only referenced the Wandergaurd as being placed on 5/20/15 and being resolved on 11/27/15). Review of Elopement/Wander Risk Assessment Decision Tree forms dated 7/16/15 and 9/4/15 staff documented the resident as not wandering in the past 6 months, even though Progress Notes revealed the resident wandered on 5/18/15 and 7/23/15, within 6 months time. Further review of Resident #9's Progress Notes revealed the following: a. Review of the resident's Progress notes dated 12/4/15 at 1:44 P.M. revealed staff found the resident standing outside next to a car and would not come in to the facility. Staff contacted a Translator, spoke to the resident and the resident came back into the facility. The Progress Note lacked investigation into the incident and lacked reference to any new interventions being put in place in regards to closer supervision of the resident. (the resident's care plan lacked reference to the same incident). Review of staff written accounts (completed on 12/11/15) of the resident being found outside alone on 12/4/15 at 1:44 P.M., revealed Staff O, Licensed Practical Nurse (LPN) documented she looked out a window of another resident's room (no time documented) and saw the resident attempting to get into her car in the facility parking lot. Staff O documented later on in the evening at approximately 6:30 P.M. or 7:00 P.M. she went outside to take a break and saw the resident outside again (for the second time that day)	F 279		

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F 279	Continued From page 4 standing next to her car. Resident #9's Progress Notes lacked any documentation of the resident being outside a second time on 12/4/15 and lacked any new intervention being put in place for closer supervision of the resident. Progress Notes dated 12/11/15 at 4:02 P.M. recorded the resident was found trying to get into cars in a parking lot. Staff brought the resident back inside the facility. Staff documented a placing a Wandergaurd on the resident's left ankle at 5:49 P.M. During interview on 12/15/15 at 1:35 P.M., Staff P, LPN, confirmed being in charge of the resident's care on 12/4/15, during the day shift. Staff P confirmed not implementing a new intervention for closer supervision of the resident. During interview on 12/17/15 at 8:50 A.M., the Director of Nursing stated at the time of a resident being found outside alone, such as in the case of Resident #9, she expected nurses to report the incident right away to the Administrator and herself, make sure the resident is safe, fill out an Exit or Exit Attempt Report form, re-assess the resident's wander risk and implement some type of intervention.	F 279		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 5	F 323		

This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, policy review and interviews, the facility failed to provide adequate supervision and monitoring to protect 1 of 12 residents. Resident #9 eloped from the facility without staff's knowledge twice on 12/4/15 and again on 12/11/15. Interview with the Administrator identified the main entrance door of the facility did not have an alarm to alert staff when Resident #9 had left the building. Record review and staff interviews revealed no safety provisions implemented after the elopements on 12/4/15. Resident #9 eloped again through the main door on 12/11/15 and no staff were aware the resident had left the building. Record review and staff interviews revealed Resident #9 continued to remove his/her Wanderguard devices both before and after these elopements. The findings constitute an immediate jeopardy to resident ' s health and safety. The sample consisted of 12 residents and the facility reported a census of 98 residents.

Findings included:

According to a Minimum Data Set (MDS) assessment with an assessment reference date of 11/29/15, Resident #9's diagnosis included: Non-Alzheimer's Dementia, psychotic disorder, depression and diabetes mellitus. The MDS identified the resident with long and short term memory problems and modified independence with cognitive skills for daily decision making. The

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F 323	Continued From page 6 MDS revealed the resident sometimes understood others and sometimes had the ability to make his/her(self) understood. The resident had not wandered during the assessment period and independently walked/ambulated without assisted devices such as a walker. The MDS identified the resident's admission to the facility as 2/2/2007. The resident's current care plan, identified the resident as speaking little English due to his/her nationality, not being able to use a communication board due to dementia progression; and sometimes made poor safety choices. The care plan included a goal to not harm his/her self or others with a date initiated date of 9/9/13 and an intervention (date initiated 5/20/15) for the resident to wear a Wandergaurd bracelet (electronic device that signals an alarm on an exit door) on the resident's leg. The same intervention identified the Wanderguard as resolved on 11/27/15. The same care plan noted concerns for activities of daily living (ADLs) and sometimes he/she needed reminders and was forgetful. The resident also had a care plan to address sexually inappropriate behaviors towards staff, like grabbing their private parts, sometimes combative and noncompliant. The care plan listed additional diagnoses that would affect the resident ' s thought process: delusional disorder, major depressive disorder, recurrent, severe with psychotic symptoms and vascular dementia without behaviors. Review of the resident's pocket care card (updated as needed by nursing staff to reflect the daily care required by a resident), dated 12/2/15, and included an approach for "FREQUENT	F 323		

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F 323	Continued From page 7 CHECKS". Review Resident #9's Progress Notes included the following documentation: a). On 5/18/15 (no time) nursing staff found the resident wandering in the halls and staff placed a Wanderguard on the resident's left wrist. b). On 7/23/15 at 4:05 A.M., (as noted above), nursing staff found the resident walking in a back employee hallway and applied a Wanderguard. (Note: the resident's progress notes and care plan, lacked documentation as to when staff discontinued the resident's Wanderguard after placed on 5/18/15. The care plan lacked documentation in regards to the Wanderguard being placed back on the resident on 7/23/15). c). On 7/24/15 at 10:39 P.M., nursing staff documented the resident removed his/her Wanderguard from his/her left ankle. The resident ' s family was at the facility and translated to the resident to keep the Wanderguard on. The resident's family found 2 Wanderguard bracelets under the resident's bed and the facility had no other Wanderguard bracelets available at this time. Staff implemented 15 minute checks. (Note: the care plan lacked reference to the resident's refusal to leave the Wanderguard on and/or the implementation of the 15 minute checks). d). On 8/5/15 at 6:08 P.M., nursing staff documented the resident's 15 minute checks as discontinued and the Wanderguard remained off the resident. (The care plan lacked reference to the resident's 15 minute checks being	F 323		

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F 323	Continued From page 8	F 323		

discontinued and no further use of a Wanderguard. As noted above, the care plan only referenced the Wanderguard as being placed on 5/20/15 and being resolved on 11/27/15).

Review of Elopement/Wander Risk Assessment Decision Tree forms dated 7/16/15 and 9/4/15 staff documented the resident as not wandering in the past 6 months; (note Progress Notes dated 5/18/15 and 7/23/15 identified the resident wandered within 6 months time.)

Review of an Elopement /Wander Risk Assessment Decision Tree form dated 11/27/15 revealed a portion of the assessment included a question in regards to the resident wandering (either in the facility or elsewhere) within the past 6 months and staff documented the answer to the question as "No".
(Note: A Progress Noted dated 7/23/15 at 4:05 A.M., revealed staff documented the resident as found walking in a back employee hallway and staff applied a Wanderguard to the resident's leg at 1:52 P.M. This occurred approximately 4 months prior to the Wander Risk Assessment completed on 11/27/15 at the time staff documented the resident as having no wandering during the past 6 months)

Review of a Physician's Orders form, signed by a Physician on 12/2/15, included an informational order for Wander Risk per nursing judgement, with a start date of 8/21/2012.

1). Further review of Resident #9's Progress Notes revealed the following:
On 12/4/15 at 1:44 p.m., nursing staff documented the resident as found standing

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F 323	Continued From page 9 outside next to a car and would not come in to the facility. Staff contacted a Translator, spoke to the resident and the resident came back into the facility. The staff documented the resident reported he/she had been waiting for his/her family to arrive; and staff attempted to reach Resident #9 ' s family. The Progress Note lacked investigation into the incident and lacked reference to any new interventions being put in place in regards to closer supervision of the resident. (The resident's care plan lacked reference to the same incident.) The following are interviews of varying staff accounts from staff members on duty at the time of the resident being found outside alone on 12/4/15 at 1:44 P.M. : On 12/15/15 at 12:45 P.M. - The facility Social Worker reported she had never known the resident to go outside the facility alone. She stated a nurse notified her of the resident being outside alone on 12/4/15 and she went outside to get the resident. The Social Worker stated because of the language barrier, she could not get the resident to go back inside the facility, so she called the Translator, the Translator spoke to the resident and the resident and the Social Worker then walked the resident back into the facility. She stated the resident wore long pants, sweatshirt, hat, gloves, shoes when first outside, at some point staff took the resident a jacket and stated she felt the resident had been outside for a total of 10 minutes. The Social Worker stated the nurse in charge being aware of the resident being outside alone and stated she thought she told the nurse if the resident didn't have a Wanderguard he/she needed one.	F 323		

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F 323	Continued From page 10 On 12/15/15 at 1:00 P.M. - Staff D, Nurse Unit Manager, stated on 12/4/15 the facility receptionist had been looking out the window, he looked out the window and noticed the resident standing in a parking lot next to a car in the first parking spot (in front of Aspenwood hall). Staff D stated the resident had never been outside alone in the past or attempted to get outside alone in the past. Staff D stated the resident wore a hat, gloves, pants, long sleeve shirt, shoes and at some point a staff member brought him/her a jacket. Staff D reported not being in charge of Resident #9, but if he had been the nurse on duty after the resident went outside the facility alone, he would call the facility Director of Nursing (DON) or the facility Administrator. Staff D reported he was unsure why the resident had frequent checks on the care plan (dated 9/11/15) or who added this intervention and did not know what was meant by frequent checks. During interview on 12/15/15 at 1:10 P.M., Staff O stated on 12/4/15 at approximately 12:30 P.M., or 1:00 P.M., she and another staff member had been in another resident's bedroom. She stated she looked out the window and saw Resident #9 standing next to her car in a parking lot in the first parking spot, pulling on the passenger side door handle. During interview on 12/15/15 at 1:35 P.M., Staff P, LPN, confirmed being in charge of the resident's care on 12/4/15, during the day shift. Staff P stated she had last seen the resident sometime after lunch. She stated another Nursing Assistant reported to her the resident was outside, she went outside to get the resident at approximately 1:45 P.M. and he/she would not go back inside the facility. She stated she went	F 323		

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F 323	Continued From page 11 back inside the facility as Staff D stayed with the resident. Staff D reported the resident being outside for approximately 15 minutes. Staff P states she had never known the resident to go outside alone in the past. She stated she wondered if the resident had a Urinary Tract Infection, due to his/her behavior being different than normal (re: going outside alone). She stated she called the resident's Physician, received and antibiotic order and called no one else. Staff P stated she had not thought of the resident being outside alone as an elopement. Staff P stated in hindsight, she should have notified the facility Administrator and filled out an elopement form. Staff P confirmed not implementing a new intervention for closer supervision of the resident. Staff P reported the care plan intervention for frequent checks related to checking resident every ½ hour to one hour and staff did not need to document these checks. Staff P reported she did not know who put it in place but knew Resident #9 had gone into other resident rooms. Staff P reported she was not sure why frequently checks were put in place. A Weather Underground website, document the average air temperature on 12/4/15 at the Sioux Gateway airport as 26 degrees Fahrenheit (F). Observation on 12/16/15 at 8:50 A.M. of the first parking spot in the parking lot as described by Staff D and Staff O, measured approximately 30 feet from the main entrance door of the facility. The distance from the entryway to street measure approximately 225 feet. 2). On 12/11/15 at 4:02 p.m., - nursing staff documented the resident being found trying to get	F 323		

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F 323	Continued From page 12 into cars in a parking lot. Staff brought the resident back inside the facility. Staff documented a Wanderguard being placed on the resident's left ankle at 5:49 p.m. Review of a pocket care card, updated 12/11/15, revealed staff documented Wanderguard placed due to the resident's exit attempts and 1:1 supervision until further notice. During interview on 12/15/15 at 11:30 A.M., Staff C, Nurse Unit Manager reported not being aware the resident had been outside unaccompanied on 12/4/15 until the resident had been found outside again on 12/11/15 and she reviewed the resident's Progress Notes. Staff C stated nursing staff failed to report the incident on 12/4/15 to Administrative staff and Staff C had not been aware of any investigation into the resident leaving the building on 12/4/15 at 1:44 P.M. Staff C stated she had not been aware of the resident having any past incidents of wandering. 3). Review of various staff written accounts (completed on 12/11/15) of the resident being found outside alone on 12/4/15 at 1:44 P.M., Staff O, Licensed Practical Nurse (LPN), documented she looked out a window of another resident's room (no time documented) and saw the resident attempting to get into her car in the facility parking lot. Staff O documented later on in the evening at approximately 6:30 P.M. or 7:00 P.M., she went outside to take a break and Resident # 9 had been outside again for the second time that day standing next to her car. Review of Resident #9's Progress Notes, lacked	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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any documentation of the resident being outside a second time on 12/4/15, lacked documentation of Administrative staff being informed of the resident being outside and lacked any new intervention being put in place for closer supervision of the resident.

The following are interviews of varying staff accounts from staff members on duty at the time of the resident being found outside alone on 12/4/15 at approximately 6:30 P.M. - 7:00 P.M. :

During interview on 12/15/15 at 1:10 P.M., Staff O stated on 12/4/15 between the times of 6:30 P.M. and 7:00 P.M., she left the building to go outside to take a break. She stated once outside, she saw Resident #9 standing outside of her car in the first parking spot of the parking lot, and the resident attempted to open the door on the passenger side. Staff O stated she paged Staff N, Nursing Assistant in charge of the resident, Staff N came outside and escorted the resident back inside the facility. Staff O stated she had no memory of what the resident wore for clothing and had no knowledge of how long the resident had been outside.

During telephone interview on 12/15/15 at 3:50 P.M., Staff N confirmed being responsible for Resident #9 on 12/4/15, during the evening shift. She stated she had been aware the resident had left the facility alone earlier in the day. She stated at the time her shift began, she noted the resident wore his/her coat, hat and gloves and she tried to keep an eye on the resident in-between taking care of all the other residents. She reported she could not be certain if she had been looking for the resident, or if she saw the resident outside by looking out a window (even though Staff O stated

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F 323	Continued From page 14 she paged Staff N to let her know of the resident being outside). She thought the resident had been outside for the second time at approximately 8:00 P.M. Staff N stated the charge nurse told her to keep an eye on the resident after the resident had been found outside on the evening shift. During telephone interview on 12/15/15 at 4:10 P.M., Staff R, Registered Nurse/RN, confirmed being in charge of Resident #9's care on the evening shift of 12/4/15. Staff R confirmed being aware of the resident being outside of the facility alone earlier in the day of 12/4/15. She stated she thought the resident left the facility again on the evening shift along with Staff O when she left the building for break and didn't think about the incident being an elopement for that reason. Staff R stated she had not reported the incident to Administrative staff because there had been a staff member outside with the resident, confirmed she did no investigation into the incident and confirmed not knowing Staff O found the resident outside alone at the time she left for her break. Staff R stated the resident hadn't usually gone outside the facility alone. Staff R confirmed not initiating any new intervention for closer supervision of the resident. During interview on 12/17/15 at 9:20 a.m., Staff C confirmed no updated care plan after the resident left the facility on 12/4/15. Review of a facility Incident Description in regards to the resident being found outside on 12/11/15 at 4:00 P.M., revealed staff viewed the facility security camera footage and showed the resident left the main entrance of the facility alone at 3:57	F 323		

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F 323	Continued From page 15 P.M. and returned to the facility at 4:01 P.M. [No staff had monitored the security camera and no staff were aware the resident had left the building.] Review of a facility Exit or Exit Attempt Report form dated 12/11/15 revealed on 12/11/15 at 4:00 P.M., a facility Nurse documented a Hospice Nurse found Resident #9 outside in the facility parking lot attempting to enter a vehicle and wore pants, a t-shirt, socks and shoes. The report form identified the Administrator as being notified at 5:00 P.M. A Weather Underground website, documented the average air temperature on 12/11/15 at the Sioux Gateway airport as 23 degrees Fahrenheit. According to the National Weather Service, documented the outside temperature on 12/11/15 at 4:00 P.M., in the same city of the facility as 23 degrees Fahrenheit. Review of a Elopement /Wandering Risk Assessment Decision Tree form dated 12/11/15, staff documented the resident had no wandering during the past 6 months (even though the resident had been found outside twice on 12/4/15). 4). During the survey 12/14/15 - 12/16/15, the main entrance door (the same door Resident #9 exited from when he/she eloped) had a Wanderguard alarm and would only alarm if a resident wearing a Wanderguard device attempted to exit the door. The facility identified the main entrance door as a fire exit door. During interview on 12/15/15 at 12:00 P.M., the	F 323		

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F 323	Continued From page 16 facility Administrator confirmed the 12/4/15 in regards to the resident leaving the building had not been investigated until 12/11/5. The Administrator stated the resident's son/daughter takes the resident out on Fridays and she understood the nurse on duty had not considered the resident being outside alone (and without staffs knowledge) an elopement, but rather felt the resident went outside to wait for his/her family. The Administrator reported the resident being difficult to assess due to the language barrier and stated the facility had not viewed the resident being outside unaccompanied as an elopement, but rather the resident went outside to wait for his/her son/daughter. The Administrator reported having residents in the facility that are able to be outside without staff supervision and those resident's had not been required to check with staff prior to going outside (even though no alarm system on the main entrance door). During interview on 12/16/15 at 7:50 A.M., the Administrator explained the security camera footage as only able to view for a cycle of 2 days before it is taped over. The video re-records over itself every 24-48 hours so there was not a copy to view. [The facility did not have staff that watched the security camera recording and did not even know the resident had left the building on 12/4/15.] During telephone interview on 12/16/15 at 9:15 A.M., Staff L, LPN confirmed being in charge of Resident #9's care on the evening shift of 12/11/15. Staff L stated she had heard in report that Resident #9 had been outside the facility alone on 12/4/11. Staff L stated she received a call from the front desk that a Hospice staff	F 323		

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member had found the resident outside at approximately 4:00 P.M. and the resident had been on his/her way back to his/her living area. Staff L said she had last seen the resident sometime between 2:00 P.M. and 4:00 P.M. and the only information she received was that the resident had been in the parking lot. Staff L described herself as a new Nurse and not being aware of the facility elopement procedures. Staff L stated she placed a Wanderguard bracelet on the resident and the Administrator initiated 1:1 supervision of the resident.

During telephone interview on 12/16/15 at 10:45 A.M., Staff L, Hospice Aid confirmed being the person who found Resident #9 in the parking lot on 12/11/15. She stated not being aware of the exact time, but she sat in her car and noticed a person not known to her (Resident #9), trying to get into a car by pulling on the driver and back door handle. She stated he/she then went to another car and opened the driver side door. (The cars sat side by side in the first 2 parking spots of the double row parking.) Staff L stated at that time, she asked the resident if he/she was lost and the resident responded "yeah, yeah", the resident walked inside the facility with her and informed the receptionist. She reported the resident wore a short sleeve shirt, pajama bottoms and shoes.

Observation on 12/17/15 at 7:45 A.M.. of the first 2 parking spots in the double row parking as described by Staff K measured approximately 42 feet from the main entrance door of the facility.

Further review of Resident #9's Progress Notes revealed the resident continued to exit the building accompanied by staff as follows:

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F 323	Continued From page 18 a). On 12/12/15 at 11:23 A.M. - nursing staff documented the resident put his/her hat and gloves on, went outside and sat on a bench and would not come back inside. Staff documented the resident's 1:1 supervision staff member sat with the resident and the resident came back inside after 10 minutes. Staff unable to reach resident ' s daughter. b). On 12/13/15 at 12:51 P.M. - nursing staff documented the resident insistent on going outside, pushed a staff member away from the door, went outside with the 1:1 supervision staff member and came back inside after 1 minute. A progress note dated 12/15/15 at 6:24 documented the interpreter here at facility on 12/14/15 and explained the purpose of the Wanderguard to the resident. The interpreter stated the resident understood and agrees to wear the Wanderguard. A progress note dated 12/15/15, at 11:30 a.m., identified the interpreter present to speak with state surveyor and facility staff and the facility documented the resident stated he/she would wait inside for his/her family. c). On 12/16/15 at 9:08 A.M. - nursing staff documented the resident exited the facility at 5:20 P.M, [on 12/15/15]. with the supervision of the 1:1 staff member. Staff documented the resident opened a unknown parked van in the parking lot. Staff phone the resident's son/daughter, the son/daughter spoke to the resident on the phone and the resident returned to the facility. The resident took off his/her Wanderguard and	F 323		

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F 323	Continued From page 19 refused to put it back on. Staff provided 1:1 to monitor resident. During interview on 12/14/15 at 11:10 A.M., the surveyor asked the resident about the incident/s (through the use of a Translator), the resident reported he/she had been walking around waiting for his/her family (12/11/15), but denied attempting to get into cars in the parking lot. The resident reported it ' s easier for his/her family if he/she waits outside. The resident did not seem to understand that he/she could not go outside by him/her(self) and reported " no " he/she would never try [to]. The resident reported using a butter knife to cut off the Wanderguard bracelets and a lady [unidentified person] takes it off him/her. During an interview with the Vice President of Clinical Services on 12/15/15 at 3:40 p.m., she reported the resident does not have impaired decision making skills and the interpreter came in to complete the resident ' s BIMs on 12/14/15. The VP stated Resident #9 ' s scored a BIMS of 11 [out of 15]. During interview on 12/16/15 at 7:50 A.M., the facility Administrator stated the only alarm on the front door [main entrance door] was the Wanderguard alarm. The Administrator stated all the other exit doors have door alarms. The Administrator reported the cognitive assessment completed on 11/29/15 had not been done with the interpreter. Review of a facility policy and procedure for	F 323		

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F 323	Continued From page 20 Elopement, included the following: It is the responsibility of all personnel to report any resident attempting to leave the premises or suspected of being missing, to the charge nurse as soon as practical. Upon return of the resident to the facility, the DON or charge nurse should complete and file an incident report. Make appropriated entries into the resident's medical record. Any Elopement where the resident is not seen leaving, or has unusual circumstances is considered a reportable incident under the Vulnerable Adult Law in Minnesota. Check the requirements for reporting in other states. During interview on 12/16/15 at 9:53 A.M., the facility Administrator gave the following explanations for the dates and reasons the resident's Wanderguard bracelet had been placed and discontinued (due to the resident's record and care plan lacked the documentation) : On 5/19/15- The resident wandered the halls and a Wanderguard bracelet applied. On 6/3/15 - Based on a Elopement /Wander Risk Assessment Decision Tree form dated 6/3/15, even though staff assessed the resident as cognitively impaired, and had a history of wandering in the past 6 months, nursing staff decided to discontinue the Wanderguard bracelet. On 7/27/15 - The resident wandered in a back employee hall and staff placed on Wanderguard bracelet on the resident. On 8/5/15 - Nursing staff discontinued the Wanderguard bracelet after a sign placed in the employee hallway (in the resident's native language) indicating the hallway for employees only.	F 323		

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F 323	Continued From page 21 On 9/11/15 - "FREQUENT CHECKS" on the pocket care card had been initiated for circumstances other than the resident being outside alone. During interview on 12/17/15 at 8:50 A.M., the DON stated at the time of a resident being found outside alone, such as in the case of Resident #9, she expected nurses to report the incident right away to the Administrator and herself, make sure the resident is safe, fill out an Exit or Exit Attempt Report form, re-assess the resident's wander risk and implement some type of intervention. The DON stated not being certain what the order for Wander Risk per nursing judgment, exactly meant. On 12/11/15, the facility placed Resident #9 on 1:1 supervision on the 2-10 p.m., shift and the resident remained on 1:1 supervision 24 hours a day. The facility initiated educating staff on 12/11/16 and completed all education to staff on 12/16/15. On 12/16/15, the facility added alarms on the main entrance door (and another hall named Ginger Grove) and educated staff on the following: a). Notify the Administrator and DON immediately when a resident left or attempted to leave the facility without alerting staff. b). Complete an exit report and notify the resident ' s physician and family. c). DON/Charge Nurse will initiate immediate new intervention at the time of the event (and the interventions will be added to the care plan and care card). The interventions are not limited to using a Wanderguard, placing resident on	F 323		

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F 323	Continued From page 22 frequent checks, providing 1:1 supervision to resident and adding to 24 hour report. The surveyor verified on 12/18/15, the front door alarmed and facility staff responded to determine why the door alarmed. The immediate jeopardy (IJ) was abated on 12/16/15 when the facility implement a monitoring system (door alarm) to ensure resident ' s safety at the front door. These actions lowered the IJ from a J severity to a D severity with the need for ongoing monitoring of the front door alarm; and monitoring care plan implementation for resident safety.	F 323		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff and resident interview, the facility failed to ensure palatability of food service by serving food at appropriate food temperatures for one resident (Resident #7) of 12 residents selected for review. The facility reported a census of 98 residents. Findings include: The Minimum Data Set (MDS) assessment dated 11/5/15 identified Resident #7's mental status as intact and that s/he needed set up help from staff	F 364		

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F 364	Continued From page 23 with eating. Observation on 12/15/15 at 8:00 A.M., revealed Resident #7 laid in bed in his/her room with closed eyes. The resident's room had no lights on and a plate covered with an insulated top and drinking glasses covered with plastic wrap sat on the resident's bedside table next to his/her bed. Ongoing observation revealed that at 8:05 A.M., Staff I, Registered Nurse, entered the resident's room, woke the resident and asked the resident if he/she wanted to eat. When asked immediately afterwards, the Dietary Supervisor reported the resident's meal had been delivered to his/her room at approximately 7:45 A.M. The Dietary Supervisor went directly to the resident's room to take temperatures of the resident's food and fluids on the resident's bedside table. Constant observation revealed the Dietary Supervisor took the insulated cover off of the resident's plate and recorded the following food/fluid temperatures: a. Oatmeal - 117.7 degrees Fahrenheit (F) b. Scrambled Eggs - 98.4 degrees F c. Sausage link - 86.2 degrees F d. Milk - 56.2 degrees F The Dietary Supervisor identified the food temperatures as not within the correct range for service, removed the tray and stated she needed to deliver the resident a fresh tray. The Dietary Supervisor stated she expected Dietary Staff to awaken a resident at the time a meal tray is served in a room and/or let nursing staff know a meal tray has been delivered to a resident's room. During interview on 12/15/15 at 8:15 A.M., Staff J, Licensed Practical Nurse stated Dietary Staff are to call the nurse prior to delivering a meal tray in	F 364		

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F 364	Continued From page 24 order to watch for the delivery of the tray. During interview on 12/16/15 at 8:50 A.M., Resident #7 stated he/she normally eats all meals in his/her room. The resident stated at times the food is cold as he/she is sleeping at the time a meal tray is delivered. During interview on 12/17/15 at 8:45 A.M., the facility Director of Nursing stated she expected room trays to be delivered after a resident is awake and ready for the tray.	F 364		

F279 Care Plans

Immediate corrective action: Resident # 9 Care Plan was reviewed and additions added to assure it was comprehensive in planning for resident's risk of elopement.

Action as it applies to others: All staff who participate in care planning were trained on the need to assure the input is current, specific and comprehensive.

All other wandering residents Care Plans were reviewed and language updated if indicated to assure care needs for wandering/elopement risk are current and comprehensive

Date of completion: 1/8/2016

Recurrence will be prevented by: All residents who wander or are at risk for elopement, including new admissions, will have their Care Plans reviewed weekly x 90 days to assure they are comprehensive and current. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits.

All residents who wander or at risk for elopement will be discussed at Daily Quality Conference and any changes will be reported at that time and Care Plans reviewed to assure updated interventions if indicated have been added. This will be an ongoing process.

The correction will be monitored by: DON/Unit Managers

F323

Immediate corrective action: The nurse who failed to report to the administrator resident # 9 going into parking lot x 2 on 12/4/2015, was counseled and re-educated.

A medical examination and psychiatric assessment was performed on resident # 9 and medication management initiated. He remains on 1:1 supervision and a secured Unit is being sought.

Action as it applies to others: All staff were re-educated on the Elopement Policy and the Abuse Prevention Policy, including need to immediately report to Administrator/DON, who investigate and report to State if indicated; completing an Exit Report to include the physician and family, initiating new interventions, such as a wanderguard, 15 minute checks, 1:1 supervision and added to the Care Plan, Care Card and 24hr Report.

All residents at risk of Elopement were reassessed to assure their Care Plan interventions were current and changes made if indicated.

The Main door of the facility is now alarmed at all times. A permanent key coded system is ordered.

4 inch window closers were placed on the 14 residents at risk for elopement on 12/11/15.

Date of completion: 1/8/2016

Recurrence will be prevented by: 60 Staff are being randomly interviewed weeky and a written quiz collected to assure a clear understanding of the Elopement and Abuse Prevention Policies. This practice will continue x 30days until all current staff have been quizzed and the results of these quizzes and any additional education needed will be shared with the facility QAPI Committee for input on the need to increase, decrease the quizzes. If no changes recommended, the quizzes will continue for 30 random staff for the next 60 days and results shared with QAPI for input on the need to increase, decrease, or discontinue the quizzes.

The main door loudly alarms whenever it is opened. Drills are being held each shift for staff response time to the alarm. This practice will continue until the key coded system is installed, which is expected Jan 25, 2016.

Elopement Drills are being held 3x weekly, each one on different shifts, x 30 days; then 1x weekly each time on a different shift x 30 days; then monthly, each time on a different shift ongoing.

All residents identified at risk for wandering/elopement, including new admissions, will have their Care Plans reviewed weekly x 90 days to assure the interventions are comprehensive and current. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits.

All residents who wander or at risk of elopement are reviewed at morning Quality Conference and Care Plans reviewed if there has been a change or a need for a new intervention. This will be an ongoing practice.

F364

Immediate corrective action: When Resident # 7 awakened, her breakfast tray was removed by the nurse and a new hot tray obtained.

Action as it applies to others: Education was provided to the dietary and nursing staff on the revised room tray service, to include not leaving a tray if the resident is sleeping and unable to be aroused, and to report to the resident's nurse.

Immediate visual audits of all breakfast room trays began on 12/15/15 and lunch and supper audits have been added.

Date of completion: 1/8/2016

Recurrence will be prevented by: All room trays will be monitored each meal x90 days to assure no trays are left for a resident who is sleeping and cannot be awakened. The nurse will be notified and a tray obtained once the resident awakens. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits.

All food served is temped prior to being served from the Steam Table each meal.

The correction will be monitored by: Dietary Manager/Designee

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0429	A. BUILDING: _____ B. WING _____	C 12/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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) COMPLETE DATE
N 104	50.7(4) 481- 50.7 (10A,135C) Additional notification 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. This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to report the elopement of a resident with impaired decision making ability, to the Iowa Department of Inspections and Appeals within 24 hours or the next business day (Resident #9). The sample consisted of 12 residents and the facility reports a census of 98 residents. Findings included: According to a Minimum Data Set (MDS) assessment with an assessment reference date of 11/29/15, Resident #9's diagnosis included: Non-Alzheimer's Dementia, psychotic disorder, depression and diabetes mellitus. The MDS identified the resident with long and short term memory problems and modified independence with cognitive skills for daily decision making. The MDS revealed the resident sometimes understood others and sometimes had the ability to make his/her(self) understood. The resident had not wandered during the assessment period and independently walked/ambulated without	N 104		

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N 104	Continued From page 1 assisted devices such as a walker. The MDS identified the resident's admission to the facility as 2/2/2007. The resident's current care plan, identified the resident as speaking little English due to his/her nationality, not being able to use a communication board due to dementia progression; and sometimes made poor safety choices. The care plan included a goal to not harm his/her self or others with a date initiated date of 9/9/13 and an intervention (date initiated 5/20/15) for the resident to wear a Wanderguard bracelet (electronic device that signals an alarm on an exit door) on the resident's leg. The same intervention identified the Wanderguard as resolved on 11/27/15. The same care plan noted concerns for activities of daily living (ADLs) and sometimes he/she needed reminders and was forgetful. The resident also had a care plan to address sexually inappropriate behaviors towards staff, like grabbing their private parts, sometimes combative and noncompliant. The care plan listed additional diagnoses that would affect the resident ' s thought process: delusional disorder, major depressive disorder, recurrent, severe with psychotic symptoms and vascular dementia without behaviors. Review of Elopement/Wander Risk Assessment Decision Tree forms dated 7/16/15 and 9/4/15 staff documented the resident as not wandering in the past 6 months; (note Progress Notes dated 5/18/15 and 7/23/15 identified the resident wandered within 6 months time.) Review of an Elopement /Wander Risk Assessment Decision Tree form dated 11/27/15 revealed a portion of the assessment included a	N 104		

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N 104	Continued From page 2 question in regards to the resident wandering (either in the facility or elsewhere) within the past 6 months and staff documented the answer to the question as "No". (Note: A Progress Noted dated 7/23/15 at 4:05 A.M., revealed staff documented the resident as found walking in a back employee hallway and staff applied a Wanderguard to the resident's leg at 1:52 P.M. This occurred approximately 4 months prior to the Wander Risk Assessment completed on 11/27/15 at the time staff documented the resident as having no wandering during the past 6 months) 1). Further review of Resident #9's Progress Notes revealed the following: On 12/4/15 at 1:44 p.m., nursing staff documented the resident as found standing outside next to a car and would not come in to the facility. Staff contacted a Translator, spoke to the resident and the resident came back into the facility. The staff documented the resident reported he/she had been waiting for his/her family to arrive; and staff attempted to reach Resident #9 ' s family. The Progress Note lacked investigation into the incident and lacked reference to any new interventions being put in place in regards to closer supervision of the resident. (The resident's care plan lacked reference to the same incident.) 2. Review of various staff written accounts (completed on 12/11/15) of the resident being found outside alone on 12/4/15 at 1:44 P.M., Staff O, Licensed Practical Nurse (LPN), documented she looked out a window of another resident's room (no time documented) and saw the resident attempting to get into her car in the	N 104		

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N 104	Continued From page 3 facility parking lot. Staff O documented later on in the evening at approximately 6:30 P.M. or 7:00 P.M., she went outside to take a break and Resident # 9 had been outside again for the second time that day standing next to her car. During interview on 12/15/15 at 11:30 A.M., Staff C, Nurse Unit Manager reported not being aware the resident had been outside unaccompanied on 12/4/15 until the resident had been found outside again on 12/11/15 and she reviewed the resident's Progress Notes. Staff C stated nursing staff failed to report the incident on 12/4/15 to Administrative staff and Staff C had not been aware of any investigation into the resident leaving the building on 12/4/15 at 1:44 P.M. Staff C stated she had not been aware of the resident having any past incidents of wandering. Review of Resident #9's Progress Notes, lacked any documentation of the resident being outside a second time on 12/4/15, lacked documentation of Administrative staff being informed of the resident being outside and lacked any new intervention being put in place for closer supervision of the resident. The following are interviews of varying staff accounts from staff members on duty at the time of the resident being found outside alone on 12/4/15 at 1:44 P.M. : On 12/15/15 at 12:45 P.M. The facility Social Worker reported she had never known the resident to go outside the facility alone. She stated a nurse notified her of the resident being outside alone on 12/4/15 and she went outside to get the resident. The Social Worker stated	N 104		

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N 104	Continued From page 4 because of the language barrier, she could not get the resident to go back inside the facility, so she called the Translator, the Translator spoke to the resident and the resident and the Social Worker then walked the resident back into the facility. She stated the resident wore long pants, sweatshirt, hat, gloves, shoes when first outside, at some point staff took the resident a jacket and stated she felt the resident had been outside for a total of 10 minutes. The Social Worker stated the nurse in charge being aware of the resident being outside alone and stated she thought she told the nurse if the resident didn't have a Wanderguard he/she needed one. On 12/15/15 at 1:00 P.M. Staff D, Nurse Unit Manager, stated on 12/4/15 the facility receptionist had been looking out the window, he looked out the window and noticed the resident standing in a parking lot next to a car in the first parking spot (in front of Aspenwood hall). Staff D stated the resident had never been outside alone in the past or attempted to get outside alone in the past. Staff D stated the resident wore a hat, gloves, pants, long sleeve shirt, shoes and at some point a staff member brought him/her a jacket. During interview on 12/15/15 at 1:35 P.M., Staff P, LPN, confirmed being in charge of the resident's care on 12/4/15, during the day shift. Staff P stated she had last seen the resident sometime after lunch. She stated another Nursing Assistant reported to her the resident was outside, she went outside to get the resident at approximately 1:45 P.M. and he/she would not go back inside the facility. She stated she went back inside the facility as Staff D stayed with the resident. Staff D reported the resident being	N 104		

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N 104	Continued From page 5 outside for approximately 15 minutes. Staff P states she had never known the resident to go outside alone in the past. She stated she wondered if the resident had a Urinary Tract Infection, due to his/her behavior being different than normal (re: going outside alone). She stated she called the resident's Physician, received and antibiotic order and called no one else. Staff P stated she had not thought of the resident being outside alone as an elopement. Staff P stated in hindsight, she should have notified the facility Administrator and filled out an elopement form. Staff P confirmed not implementing a new intervention for closer supervision of the resident. The following are interviews of varying staff accounts from staff members on duty at the time of the resident being found outside alone on 12/4/15 at approximately 6:30 P.M. - 7:00 P.M. : During interview on 12/15/15 at 1:10 P.M., Staff O stated on 12/4/15 at approximately 12:30 P.M., or 1:00 P.M., she and another staff member had been in another resident's bedroom. She stated she looked out the window and saw Resident #9 standing next to her car in a parking lot in the first parking spot, pulling on the passenger side door handle. Staff O stated between the times of 6:30 P.M. and 7:00 P.M., she left the building to go outside to take a break. She stated once outside, she saw Resident #9 standing outside of her car in the first parking spot of the parking lot, and the resident attempted to open the door on the passenger side. Staff O stated she paged Staff N, Nursing Assistant in charge of the resident, Staff N came outside and escorted the resident back inside the facility. Staff O stated she had no memory of what the resident wore for clothing and had no knowledge of how long the resident had been outside.	N 104		

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N 104	Continued From page 6 During telephone interview on 12/15/15 at 4:10 P.M., Staff R, Registered Nurse/RN, confirmed being in charge of Resident #9's care on the evening shift of 12/4/15. Staff R confirmed being aware of the resident being outside of the facility alone earlier in the day of 12/4/15. She stated she thought the resident left the facility again on the evening shift along with Staff O when she left the building for break and didn't think about the incident being an elopement for that reason. Staff R stated she had not reported the incident to Administrative staff because there had been a staff member outside with the resident, confirmed she did no investigation into the incident and confirmed not knowing Staff O found the resident outside alone at the time she left for her break. Staff R stated the resident hadn't usually gone outside the facility alone. Staff R confirmed not initiating any new intervention for closer supervision of the resident. During interview on 12/15/15 at 12:00 P.M., the facility Administrator confirmed the 12/4/15 in regards to the resident leaving the building had not been investigated until 12/11/5 [when another elopement occurred]. The Administrator stated the resident's son/daughter takes the resident out on Fridays and she understood the nurse on duty had not considered the resident being outside alone (and without staffs knowledge) an elopement, but rather felt the resident went outside to wait for his/her family. The Administrator reported the resident being difficult to assess due to the language barrier and stated the facility had not viewed the resident being outside unaccompanied as an elopement, but rather the resident went outside to wait for his/her son/daughter. The Administrator reported having	N 104		

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N 104	Continued From page 7 residents in the facility that are able to be outside without staff supervision and those resident's had not been required to check with staff prior to going outside (even though no alarm system on the main entrance door). During an interview with the Vice President of Clinical Services on 12/15/15 at 3:40 p.m., she reported the resident does not have impaired decision making skills and the interpreter came in to complete the resident ' s BIMs on 12/14/15. The VP stated Resident #9 ' s scored a BIMS of 11 [out of 15]. During interview on 12/16/15 at 7:50 A.M., the facility Administrator stated the cognitive assessment completed on 11/29/15 had not been done with the interpreter. Review of a facility Exit or Exit Attempt Report form included a notation at the bottom of the form in regards to a state rule and an elopement of a resident. The form included " ...For the purposes of this subrule, " elopes " means when a resident who has impaired decision-making ability leaves the facility without knowledge or authorization of staff ... " Review of a facility policy and procedure for Elopement, included the following: *It is the responsibility of all personnel to report any resident attempting to leave the premises or suspected of being missing, to the charge nurse as soon as practical. *Upon return of the resident to the facility, the DON or charge nurse should complete and file an incident report. *Make appropriated entries into the resident's medical record. *Any Elopement where the resident is not seen	N 104		

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N 104	Continued From page 8 leaving, or has unusual circumstances is considered a reportable incident under the Vulnerable Adult Law in Minnesota. Check the requirements for reporting in other states. During interview on 12/17/15 at 8:50 A.M., the DON stated at the time of a resident being found outside alone, such as in the case of Resident #9, she expected nurses to report the incident right away to the Administrator and herself, make sure the resident is safe, fill out an Exit or Exit Attempt Report form, re-assess the resident's wander risk and implement some type of intervention. The facility failed to report the resident being outside the facility without knowledge of or authorization from staff on 2 separate incidents on 12/4/15, to the Department of Inspections and Appeals.	N 104		

N104

Immediate corrective action: The nurse who failed to report to the administrator resident # 9 going into parking lot x 2 on 12/4/2015, was counseled and re-educated.

A medical examination and psychiatric assessment was performed on resident # 9 and medication management initiated. He remains on 1:1 supervision and a secured Unit is being sought.

Action as it applies to others: All staff were re-educated on the Elopement Policy and the Abuse Prevention Policy, including need to immediately report to Administrator/DON who then investigate and Report to the State if indicated; completing an Exit Report to include the physician and family, initiating new interventions, such as a wanderguard, 15 minute checks, 1:1 supervision and added to the Care Plan, Care Card and 24hr Report.

All residents at risk of Elopement were reassessed to assure their Care Plan interventions were current and changes made if indicated.

The Main door of the facility is now alarmed at all times. A permanent key coded system is ordered.

4 inch window closers were placed on the 14 residents at risk for elopement on 12/11/15.

Date of completion: 1/8/2016

Recurrence will be prevented by: 60 Staff are being randomly interviewed weeky and a written quiz collected to assure a clear understanding of the Elopement and Abuse Prevention Policies. This practice will continue x 30days until all current staff have been quizzed and the results of these quizzes and any additional education needed will be shared with the facility QAPI Committee for input on the need to increase, decrease the quizzes. If no changes recommended, the quizzes will continue for 30 random staff for the next 60 days and results shared with QAPI for input on the need to increase, decrease, or discontinue the quizzes.

The main door loudly alarms whenever it is opened. Drills are being held each shift for staff response time to the alarm. This practice will continue until the key coded system is installed, which is expected Jan 25, 2016.

Elopement Drills are being held 3x weekly, each one on different shifts, x 30 days; then 1x weekly each time on a different shift x 30 days; then monthly, each time on a different shift ongoing.

All residents identified at risk for wandering/elopement, including new admissions, will have their Care Plans reviewed weekly x 90 days to assure the interventions are comprehensive and current. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits.

All residents who wander or at risk of elopement are reviewed at morning Quality Conference and Care Plans reviewed if there has been a change or a need for a new intervention. This will be an ongoing practice.

The correction will be monitored by: Administrator/DON