STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165350	A. BUILDING _____ B. WING _____	C 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND CARE CENTER	1501 OFFICE PARK ROAD WEST DES MOINES, IA 50265

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F 000 ✓ ok/CP	INITIAL COMMENTS Correction date: 11/17/24 The following deficiencies resulted from investigation of complaint #124347-C and facility reported incidents #124267-I and #124302-I conducted October 23, 2024 to October 31, 2024. Complaints #124347-C was substantiated. Facility reported incident #124267-I and #124302-I were substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family and staff interviews, hospital notes, Emergency Medical Service (EMS) report and policy review, the facility failed to ensure residents were adequately supervised for 1 of 3 resident's reviewed for elopement (Resident #1). The facility staff failed to know Resident #1 left the facility unattended, was severely cognitively impaired and wore a wander guard bracelet to alert staff if attempting to leave the facility. Resident #1 was last seen by staff on 10/21/24 at	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: Admin | (X6) DATE: 11/17/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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approximately 1:45 PM. The resident ambulated approximately 0.2 miles from the facility and suffered a fall. The EMS was called and they alerted the facility on 10/21/24 at approximately 2:15 PM that the resident had fallen and would be transported to the Emergency Department (ED) for evaluation. The facility failed to provide adequate supervision to prevent 1 of 4 residents, who the facility identified as being at risk for elopement, from exiting the facility unsupervised.

The State Agency informed the facility on 10/28/24 at 5:30 PM of the Immediate Jeopardy (IJ) that began as of 10/21/24. The facility staff removed the IJ on 10/29/24 through the following actions:
a. Residents at risk for elopement were re-evaluated using Point Click Care (PCC) (facility's electronic health care system) elopement risk assessment tool, care plans were updated, and wander guards were checked for appropriate functioning.
b. All doors were immediately checked for proper functioning, and no concerns were identified. A call was placed to make an appointment to have doors and alarms inspected. This was completed on 10/23/24, with no active issues regarding door functioning and alarm systems.
c. Immediate education with all staff provided on the elopement and wander guard policy and will continue to educate until all staff have been thoroughly informed and trained.
d. The Minimum Data Set (MDS) coordinator reviewed section E of the MDS and associated Care Area Assessments (CAA). Care plans were reviewed and updated to reflect the audit findings. Concerns were not identified.
e. The Director of Nursing (DON) or designee will audit all new admissions for elopement risk and

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ensure interventions are in place.
f. On 10/24/24, the Interdisciplinary Team (IDT) reviewed the most recent fall risk assessments for all resident identified as potentially at risk for falls. Residents determined to be at risk have completed care plan updates, and the interventions currently in place are appropriate.
g. The IDT ensured that all residents identified as "at risk" for falls had safety measures and resident-specific interventions added to their care plans.
h. The IDT ensured that the safety measures and resident-specific interventions added to the care plans were also reflected on the Kardex so the Certified Nurses Assistants (CNAs) had access to this information.
i. The DON and designee(s) instructed the CNA's to review the updated Kardex before their next shift.

The scope lowered from a "J" to an "G" at the time of the survey after ensuring the facility implemented education and made appropriate changes to their process and procedures.

The facility identified a census of 68 residents.

Findings include:

The Admission MDS assessment dated 8/24/24 revealed Resident #1 admitted to the facility on 10/21/22 and had diagnoses of Alzheimer's disease, dementia, seizure disorder, a hip fracture, malnutrition, depression, osteoporosis, tachycardia, history of falling, and dizziness. The MDS recorded the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 indicating severe cognitive impairment. The resident had wandering behavior that occurred

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daily. The MDS indicated the resident used a walker and had independence for toileting, dressing, bed mobility and transfers. The MDS documented the resident had a life expectancy of 6 months or less and was receiving hospice care. It further documented the resident had a wander/elopement alarm used daily.

The Care Plan initiated on 11/11/22 revealed the resident had a self-care deficit in activities of daily living (ADL's) related weakness and decreased mobility secondary to diagnoses of convulsions, Alzheimer's disease and osteoporosis. The resident transferred and ambulated independently using a four-wheeled walker. The Care Plan revealed the resident was receiving hospice services, took medication for depression and a seizure disorder, and an opioid medication as needed for pain management related to hospice care and the resident had a risk for falls. The Care Plan further documented a Focus Area for resident being at risk for elopement. Interventions for staff included: wander guard to left ankle and check for proper function every shift, encourage participation in activity program, signage outside the resident's room so resident can locate correct room and consider any pattern of exit seeking need or behavior to alter resident schedule, treatment, medications or environment to manage behavior and ensure safety.

An Admission Assessment dated 11/11/22 completed by Staff A, Licensed Practical Nurse (LPN), revealed Resident #1 admitted from the hospital. Resident alert and oriented to person, place and time and not deemed an elopement risk at that time.

An Elopement Risk Assessment completed on

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1/28/24 by Staff B, LPN, revealed Resident #1 had a score of 13 indicating resident was at risk for elopement. A wander guard bracelet was applied at that time.

The Clinical Physician Orders documented an order dated 1/28/24 for a wander guard safety device. Please verify that device is in place and working. Replace if non-functioning.

A Quarterly/Comprehensive Assessment was completed on 8/24/24 and the Elopement Risk Assessment revealed a score of 19 indicating the resident to be at risk for elopement.

Progress Notes dated 1/1/24 through 10/21/24 indicated the following related to exit seeking and elopement:
a. 1/8/24 at 1:54 PM - Social Services made resident and family aware of room move to be completed. Stated no concerns.
b. 1/11/24 at 2:16 PM - Social Services noted resident was moved to new room, and reoriented to room.
c. 1/12/24 at 7:31 PM - Nursing noted resident was transitioning to new room without difficulty. Up an about per norm today. No other concerns.
d. 1/14/24 at 6:04 PM - Nursing noted resident presenting with increased confusion this shift. Continues to go to 300 hall to look for his room. When he finds his items are no longer there he walks around the halls looking for his new room. Redirected resident to room 4 times prior to evening meal. Resident is very pleasant and always grateful to be brought back home.
e. 1/28/24 at 7:00 PM - Nursing noted Resident #1 observed walking towards front exit door to look out window and within seconds the front door alarm sounded. Staff B, LPN responded to

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alarm immediately. Resident seen walking out the door and down the front walkway. Resident then turned to the right following sidewalk. Staff B followed behind resident calling his name. Resident heard his name and turned around. Asked resident "what he was doing out here?" Resident replied "my house is just up this street." pointing to the sidewalk. Attempted to re-orient resident that "he has lived at the facility since he became ill and it was pretty chilly to be walking around outside." Resident agreed "it is chilly." and was agreeable that he did live at the community and we could go back. Resident was escorted back to his room. Given comfort meds for restlessness. Reassessed for elopement risk with a score of 13 and at risk for elopement. A wander guard applied at this time. Hospice, Power of Attorney (POA), and Administration notified of attempted elopement and addition of wander guard. Primary Care Provider (PCP) on-call notified and order obtained.
f. 1/29/24 at 4:04 AM - Nursing noted resident up asking to go home. Resident stated his house was just right across the street. Resident redirected back to his room.
g. 1/29/24 at 6:14 AM - Nursing noted alarm sounding in activity dining room, resident noted by maintenance man to fall as he walked out the door. Resident fell onto left buttocks. Light blue discoloration noted to left side. Resident stated he had some pain in left buttocks. No skin issues noted. Resident then said, "the pain is gone now". Maintenance man stated resident did not hit his head. Hospice and doctor notified. Regional Nurse on-call notified.
h. 1/29/24 at 6:39 AM - Nursing noted the Power of Attorney (POA) was notified of fall.
i. 1/29/24 at 4:00 PM - Nursing noted the resident attempting to go out front door. Staff with

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resident. Resident insisted on going outside. Three staff members walked with resident. Resident insisted on walking around the building looking for his house. Resident assisted into maintenance door of building.
j. 1/29/24 at 4:18 PM - Nursing noted a call was placed to hospice and family by social services to see if family would come visit or hospice would send someone to see resident. Music therapist from hospice with the resident at this time.
k. 1/30/24 at 10:51 AM - Social Services noted the resident has had some increased confusion and wandering last few days. Hospice volunteer was in house to help with resident getting more acclimated to his room.
l. 1/30/24 at 2:12 PM - Nursing noted no wandering or exit seeking behaviors this shift. Urinalysis (UA) sent to lab, awaiting results. No behaviors noted.
m. 1/30/24 at 8:24 PM - Nursing noted resident remains on 15 minute checks, no wandering noted. Resident has been staying in room.
n. 2/1/24 at 1:59 PM - Nursing noted no exit seeking behaviors.
o. 2/1/24 at 8:17 PM - Activities noted resident has had no exit seeking behaviors today. He has been to meals in dining room and ambulates around inside of facility. Denies having any lower abdominal discomfort or dysuria. No abnormal urine odors reported. Continues on fall follow up. Denies acute pain.
p. 2/2/24 at 3:00 AM - Nursing noted resident currently resting quietly in bed. Resident has not been up and down the hall this shift or exit seeking. Resident has not exited the facility in the past 3 days and therefore, the 15 minute checks is suspended at this time. Call light within reach.
q. 3/1/24 at 9:30 AM - Nursing noted the

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maintenance manager came to nurse and informed that resident followed him outside when maintenance manager was going to his work shed. Maintenance manager noticed resident coming through the facility door and assisted resident in turning around and brought resident back inside. DON, Administrator, Advanced Registered Nurse Practitioner (ARNP), POA and also hospice notified.
r. 3/4/24 at 8:20 AM - The Interdisciplinary team (IDT) met to discuss resident exiting with maintenance person. Redirected easily at this time. No injuries noted. No changes noted to cognition, function or behavior. Immediate intervention was to call hospice and provide distraction. Encourage to participate in activities in community and request increase visit from hospice music therapist.
s. 4/5/24 at 10:09 AM - The IDT met to discuss resident's exit seeking behaviors. Resident's room is down the hall away from the exit door. Resident is ambulatory and independent with his walker. Resident is very restless, anxious. Resident likes to ambulate. Resident is on hospice services. Registered Nurse (RN) will notify hospice of resident's behaviors and have them come assess resident. Resident continues to wear his wander guard. Staff will continue to monitor. Will follow up next week to discuss resident. Resident likes to watch the birds
t. 4/16/24 at 3:26 PM - Nursing noted resident has been observed wandering and attempting to go outside, resident easily re-directed and now resting in room.
u. 6/5/24 3:45 PM - Nursing noted resident exit seeking. Resident redirected. Hospice and POA notified.
v. 6/17/24 at 3:11 PM - Nursing noted resident went out the side door of the facility. Staff

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acknowledged resident was outside. Staff assisted resident back inside the building. Staff offered to take resident for a walk, resident declined. Resident offered coffee. Resident went to the dining room for coffee.
w. 7/18/24 at 9:49 AM - Nursing noted resident has been exit seeking this morning. Staff have redirected resident with coffee. Resident in the dining room drinking coffee and people watching.
x. 7/18/24 at 1:07 PM - Nursing noted resident has been exit seeking most of the shift. Staff are re-directing resident, offering coffee, offered to sit and talk with resident. Hospice and POA notified.
y. 7/19/24 at 10:52 AM - Nursing noted resident's POA, hospice, and case manager notified of resident's exit seeking.
z. 7/20/24 at 1 :45 PM - Nursing noted resident continues to be exit seeking, resident re-directed.
aa. 7/21/24 at 11:45 AM - Nursing noted resident continues to be exit seeking this shift, resident not easily re-directed.
bb. 7/21/24 at 5:50 PM - Nursing noted resident has not been exit seeking on this shift. Continue to monitor. Wander guard noted to be in place and functioning properly.
cc. 7/22/24 at 1:39 PM - Nursing noted no exit seeking reported this shift. Hospice nurse here today and took resident outside. Resident has not voiced desire to leave facility.
dd. 7/22/24 at 9:33 PM - Nursing noted resident has had no exit seeking behavior this shift.
ee. 8/3/24 at 10:46 AM - Nursing noted resident has been exit seeking most of the shift, resident not easily redirected. Call placed to family to come and sit with resident
ff. 8/6/24 at 1:00 PM - Nursing noted resident has been exit seeking throughout the building. Resident is easily redirected with a cup of coffee, a snack, or 1:1. Hospice updated.

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gg. 8/8/24 at 4:15 PM - Nursing noted resident continues to be exit seeking, resident not easily redirected. Family has been notified and came in to visit.
hh. 8/21/24 at 12:54 PM - Nursing noted no exit seeking behaviors thus far into shift.
Resident remains hospice level of care, no acute changes or concerns. All medications and treatments administered per orders. Will continue to monitor
ii. 8/30/24 at 10:55 AM - Nursing noted they talked with hospice about resident being very addiment about leaving. Hospice directed to give PRN (as needed) lorazepam and morphine. Also called POA to see if family could come visit. Will call back in an hour.
jj. 10/21/24 at 6:00 PM - Nursing noted per hospice phone call to the facility resident has a C1 and C2 fracture. He has a C-collar on. Unsure at this time regarding discharge plan. Resident will see neurosurgeon.
kk. 10/21/24 at 8:16 PM - IDT met to discuss resident exiting the facility, at this time root cause analysis reveals resident exited immediately following a hospice visit. New intervention, care conference scheduled with family and hospice to ensure visitors check out with facility staff prior to leaving so the facility can provide diversional activities. Resident remains in the hospital at this time will monitor for changes and update the plan of care as indicated.
ll. 10/21/24 at 10:36 PM - Nursing noted EMS came to facility. Asked if resident lived here. EMS reported resident was found outside and had fallen. 911 called by a neighbor. EMS came to the facility for a face sheet and medication list. They are taking him to the hospital.

The Treatment Administration Record (TAR)

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dated 10/1/24 through 10/31/24 revealed orders for the following:
a. To monitor for refusal of care, withdrawn, or social isolation. Note that specific behaviors for individual resident will be documented in resident's progress note when behavior is identified. Complete every shift for behavior. Observations select "N" if monitored and no behaviors were observed. Select "Y" if monitored and behaviors were observed. Select chart code "Behavior observation" and document behaviors in progress note. Started 10/6/23.
b. Resident has wander guard safety device. Please verify that device is in place and working. Replace if non-functioning every shift related to Alzheimer's disease, + working and - not working. Started 1/28/24. Documentation indicated it was checked and functioning on day shift on 10/21/24.

An EMS report created at 1:55 PM on 10/21/24 revealed the ambulance was dispatched to a private residence for a fall. Upon arrival at 2:02 PM, the patient was found in a right lateral recumbent position. Bystanders on scene stated that their neighbor had seen an elderly man lying on the ground outside of their home via the ring doorbell. The neighbors who owned the property where the patient was located, called the bystanders to check on the patient. Patient stated that he was currently a resident at a nearby facility. Patient stated he was bored and wanted to take a walk. Patient ended up walking approximately 2 blocks away from the facility prior to the fall. Patient denied loss of consciousness from the fall. Patient originally stated he was on a blood thinner. Patient stated he was having pain in his neck from the fall. Patient denied pain anywhere else in his body. EMS staff were able to obtain further information on the patient from

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the nearby facility. Per the EMS staff the facility staff reported the patient was on hospice care and was currently a resident of the facility. Staff stated they had no idea the patient had left the facility. Medication and medical history list were provided by staff. Medication list revealed patient was not currently taking a blood thinner. Upon assessment, patient was alert and oriented to baseline. Patient has a history of Alzheimer's and was able to answer the majority of questions but still had baseline confusion. Patient's airway was patent, breathing was non-labored. Skin was pink, warm and dry. Patient's pupils were equal and reactive. Upon physical assessment, patient neck was palpated which revealed pain and tenderness. Patient rated his pain 9/10 in his neck. Patient was also noted to have a minor abrasion to the top of his head. Patient was placed in a c-collar. Patient was placed on a scoop stretcher and lifted to the cot. Patient was removed from scoop stretcher and placed in a supine position. Patient was administered 4 mg of Zofran prior to Fentanyl administration due to spinal immobilization, patient having a history of Zofran use and concern for vomiting. Due to patient's pain, patient was administered 40 mcg of Fentanyl. Patient appeared much more comfortable after administration and patient positioning. Patient was noted to close his eyes during transport. Patient arrived at the ED at 2:36 PM and placed in a room and was sheet lifted to hospital bed while c-spine was held mid-line. Patient was left with his belongings.

ED report dated 10/21/24 at 2:43 PM revealed resident was brought to the ED via ambulance and admitted to the hospital on 10/23/24 at 3:10 PM with report of unwitnessed fall. Resident is under hospice care at a nursing home and was

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found 2 blocks away. Complains of head and neck pain. Denied loss of consciousness. History of Alzheimer's. Diagnoses included closed displaced fracture of first cervical vertebra, closed odontoid fracture (fracture of C2 vertebrae) and abrasion on scalp without infection. Of note, according to family, the resident had been recommended to be an elopement risk from the facility, and had an ankle bracelet that was supposed to notify staff if he attempted to exit the building. It appears facility staff were unaware that the resident had exited the building until after he had sustained his injury. Neurosurgery management recommendation for the cervical spine fractures will be immobilization in a cervical collar. Family made aware of the significantly elevated risk of aspiration given acute cervical spine fractures and necessity for cervical spine immobilization.

An Elopement Risk Assessment was completed on 10/21/24 after his most recent elopement with a score of 20 putting the resident at risk for elopement related to resident being mobile with a walker, verbalization of desire or plan to leave the facility unsupervised, Alzheimer's disease, being cognitively impaired and being on 2 or more medications including psychoactive's.

Per the Incident Report dated 10/21/22 at 10:28 PM competed by the DON, at approximately 2:14 PM EMS came to the facility asking if Resident #1 resided here, once confirmed EMS requested a face sheet and medication list. Information given to EMS. EMS reported to DON that the resident was found approximately 0.2 miles away on the same road as the facility. EMS reported resident fell and a neighbor called 911. They were taking the resident to ED. Immediate action taken:

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Elopement policy and procedure education provided to the staff and an investigation was initiated. Resident taken to the hospital. Notes included:
a. On 10/21/24 at approximately at 6:00 PM the hospital called to report injury noted post evaluation included C1 and C2 Fractures. Family declined surgery. Administrator aware.
b. An IDT reviewed of the investigation completed on 10/22/24 determined that the root cause was that resident can be regimented. He travels from his room to the dining room and for coffee. If these areas are occupied this may have thrown his pattern off. Resident was last seen at 1:45 PM by housekeeping. He walked by while they were cleaning his room. When there is a deviation from his schedule it may increase confusion. New intervention is to provide diversional 1 on 1 activities when resident's visitors leave and when there is deviation from his schedule such as room cleaning.

The Facility's Investigation File revealed the following information:
Per the DON at approximately 2:15 PM on 10/21/24, EMS arrived at the facility asking if Resident #1 resided at the facility. Once the RN confirmed that the resident did reside at the facility, she provided EMS a face sheet and current medication list. EMS reported to the DON that the resident was found approximately 0.2 miles on the same road as the facility, in a residential area. One of the homeowners contacted EMS to report that this resident had fallen, and EMS was taking the resident to the ED for evaluation. Resident was able to ambulate independently throughout the facility with a four-wheeled walker. Resident had a visitor from hospice prior to lunch which could have

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potentially altered his daily routine. After lunch, the resident was returning to his room, which was being cleaned at approximately 1:45 PM, which prompted the resident to not go directly into his room as per his normal routine.

Per the Facility Investigation File permanent measures to prevent recurrence included the following:
a. 1:1 was placed immediately on the front door until confirmation of proper functioning was obtained by maintenance and all active wander guards were tested to ensure alarm function. All doors were immediately checked for proper functioning and no concerns were identified. A call was placed to make an appointment to have doors and alarms inspected. This was completed on 10/23/24, with no active issues regarding door functioning and alarm systems.
b. All residents that were at risk for elopement were re-evaluated utilizing the elopement risk assessment tool in PCC, care plans updated, and wander guards checked for appropriate functioning.
c. Immediate education with all staff provided on the elopement and wander guard policy and will continue to educate, until all staff have been educated.
d. MDS coordinator reviewed section E of the MDS and associated CAA, care plans were reviewed and updated to reflect the audit findings. Concerns were not identified.
e. The DON or designee will audit all new admissions for elopement risk and ensure interventions are in place.
f. All new hires will receive education on elopement, wandering and resident safety from the social services designee.
g. All exit doors will be checked daily for 30 days

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to ensure proper use and function.
h. A Quality Assurance Performance Improvement (QAPI) plan was implemented, and all findings will be discussed in the monthly meeting.
i. Main entrance was moved to the 1499 door, and a receptionist was placed in front of that door, and the old entrance door is no longer in use as a main entrance door and is locked per fire safety regulations. Visitors are encouraged to use the new entrance to ensure resident safety and monitoring.

The Facility Investigation File revealed the following written statements:
a. A written statement dated 10/21/24 by Staff C, Certified Nursing Assistant (CNA), stated they were on the 100 hall all day. Staff C did not see any residents leave or hear any alarms going off.
b. A written statement dated 10/21/24 by Staff D, Director of Recreation, stated at about 11:00 AM Resident #1 was sitting in the main dining room. Staff D asked the resident if he would like to have a bag of popcorn and he replied yes. Staff D then gave the resident a bag.
c. A written statement dated 10/21/24 by Staff E, Cook, stated they left at 1:55 PM and at that time Staff E, did not see any residents walking around outside when they were leaving.
d. A written statement dated 10/21/24 by staff F, Housekeeping Aide, stated they were cleaning resident #1's room at 1:45 PM and Resident #1 was walking around.
e. A written statement dated 10/21/24 by Staff D, stated Resident #1's wander guard was checked in the afternoon. Tested monitor and it was working properly on the resident's right ankle. Staff D, further stated Resident #4's wander guard was checked and was on the resident's

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right wrist and was working properly.
f. A written statement dated 10/21/24 by Staff G, Dietary Aide, stated they saw Resident #1 at lunch time around 12:30 PM
g. A written statement dated 10/21/24 by Staff H, Food Service Supervisor, stated they saw Resident #1 about 12:30 PM at lunch. Resident #1 was sitting at the table eating lunch talking to a hospice lady.
h. A written statement not dated by Staff I, CNA stated they were working on hall 2 and never heard the alarm go off or saw Resident #1 leave the building. Staff I saw the resident at lunch and walking the hall around 12:15 PM. Resident #1 was wearing dark pants, a long sleeve shirt and shoes.
i. A written statement dated 10/23/24 by the Provisional Administrator stated she had reached out to Hospice to get notes in regards to a scheduled visit for Resident #1 on the day of 10/21/24. At the time she was awaiting statements from any visitors from hospice.
J. A written statement not dated by Staff J, RN, stated they were at the nurse's station for end of shift charting. At approximately 2:20 PM a woman dressed in a uniform came into the facility. Staff J stood up from the desk to address her. She asked if she could see Resident #1. Staff J asked if they could ask who they were? She stated they had just found Resident #1 up the street. Staff J immediately walked her to the DON's office and explained the situation. Staff J stated they did not see Resident #1, they were on hall 1.

The facility provided audits on door alarms that were being completed weekly on the following dates:
8/30/24, 9/6/24, 9/13/24, 9/20/24, 9/27/24,

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10/4/24, 10/11/24, and 10/18/24.
The exits audited included:
For Fountain West: TV lounge, side conference room, patio room, hall 2, hall 3, hall 4, therapy entrance, main kitchen, main entrance and center courtyard.
For Heritage Court: north courtyard, south courtyard, front entrance, north exit and south exit.
All audits indicated alarms were functional with no problems noted.

An Elopement Drill Documentation Form stating Elopement drills are to be conducted at least twice a year and across all shifts, was completed on 10/22/24 for the day and evening shift with 43 staff signing they participated in the drill. Another Elopement drill was completed on 10/29/24 in the 300 hall with 22 staff signing they were involved in the drill. They were educated on the different types of alarms used in the facility at that time as well.

In an interview on 10/23/24 at 10:05 AM, a staff person with an outside vendor there to check the doors for safety stated they were asked to come to the facility to check on the alarmed door going from the main entrance into the long-term care (LTC) area and also the alarmed south door off the nurse's station to ensure they were functioning properly. The south door is an exterior door and the other is an interior door to enter into the LTC area. They stated the doors were functional and working correctly. The alarms were functional on both the interior and exterior door.

In an interview on 10/24/24 at 10:18 AM, a family member of Resident #1 stated the resident wore

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a wander guard bracelet all the time but they were unsure if it was functional at the time of the elopement. They reported they were not sure the facility even knew the resident was missing as the facility was not the ones who found the resident. The resident was found about 2 blocks away, at 1200 15th street. They stated that a homeowner in the community was not at home but happened to see the resident fall or on the ground on his Ring camera. He called a neighbor and asked if they would go check to see what was going on. That is when the neighbor found the resident and called the EMS. They reported the resident suffered a fracture of the C1 and C2 vertebrae. They reported that EMS had said they tried to call the facility but no one answered the phone. They reported the resident was 89 years old and was in hospice prior to this incident. They do not plan any type of surgical intervention for the resident due to resident being too frail. The resident will be in comfort care and hospice again once leaving the hospital. They reported the hospital will be keeping the resident for further observation prior to discharge as he is having increased difficulty swallowing and the hospital physician wants to monitor that for a bit. The resident is currently in a neck brace and they prefer he wear it but since he is comfort care, he can wear it as he tolerates. They stated the resident has removed it for the time being as he found it uncomfortable. The hospital has the resident's pain well controlled with the medications they are using. They reported there is currently not a discharge date planned but they know they will need to place the resident somewhere. They stated they are fearful to return the resident to this facility as they have allowed him out 3 or 4 times in the past but found him in the parking lot the other times. This time

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the resident actually got out and went up the very large hill and two blocks down the street using his walker and no one even noticed him missing it sounds like. They stated they haven't heard anything more from this facility since the initial call stating the resident had eloped, fell and was taken to the hospital.

In a phone interview on 10/28/24 at 9:53 AM, Staff K, Supervisor with hospice reported that per their records, Resident #1 was seen on 10/21/24 by Staff L, CNA with hospice from 8:01 AM to 9:07 AM for a routine visit. Staff M, Licensed Massage Therapist (LMT) with hospice was in house to see him from 1:55 PM to 2:10 PM. Staff M's notes indicated the resident was not in the room and Staff M notified the staff. No other facility visits were noted on that day. They do have documentation that they were notified at 2:27 PM by the facility DON of the resident's elopement and that he was found 2 blocks away in a residential area and EMS was called by a homeowner. Hospice spoke with the POA who was in the ED with the resident at 3:14 PM related to the need to suspend hospice services at that time.

In an interview on 10/28/24 at 11:45 AM, the Provisional Administrator stated at the time of the elopement there were 2 main entrances. One was the South entrance by the nurse's station and the other was the main entrance that was open and to the right was assisted living and the left was the nursing area. The "main entrance" that was monitored every ½ hour until midnight on 10/21/24 was the South entrance by the nurse's station. That door was locked from the outside and everyone was now being directed to the other main entrance. The main entrance was now

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staffed by a staff member Monday through Friday during daytime hours as the staff person was available. During off hours and when the staff was not present, staffknew to direct visitors as needed. The administrator reported she had not heard anything from Resident #1's family but stated she was aware they came over the weekend and removed all of the resident's personal belongings from the room. The Administrator stated she believed the resident most likely exited through the South entrance but had no way of knowing for sure. She stated the resident got up the hill and followed the road a couple of blocks straight before falling on the sidewalk. She stated the resident was last seen by staff at 1:45 PM and the EMS came to the facility at about 2:15 PM. She stated she did not think the facility knew he was missing during that time. She also verified the South door and all other doors were functional and the resident's wander guard should have alarmed as he left the facility but no staff acknowledged ever hearing the alarm go off during that approximate time frame.

In an interview on 10/30/24 at 9:53 AM, Staff N reported she started employment at the facility on 8/26/24. She reported if a resident was missing she would check their room, then the shower, then check other resident's rooms, bathrooms, check strange areas like under the bed or the closet, the main shower room should be checked and the common areas. Staff were then to check outside and notify administration. Staff N stated other staff should be informed so they can assist. Staff N stated the south door and the door entering the long-term care area were both wander guard alarms and would go off if a resident wearing a wander guard got close to it.

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The others went off if someone exits or enters the door. There was a WhatsApp and a binder that shows who has a wander guard. The information was in a binder by the nurse's station and also on the plan of care (POC) dashboard.

In an interview on 10/30/24 at 10:03 AM, Staff O, CNA stated she had worked at the facility for 3 months. She reported if a resident was found to be missing she would find out the hall they reside in and their name. Staff O stated she would talk to co-workers and see if they had seen the resident, if not she would search until the resident was found. Would notify administration right away of the missing resident. The staff would split up and some would check everywhere inside and others would look outside. Alarms can be checked quickly at the nurse's station as to where the alarm is going off. She would respond to the alarm immediately and check outside for any resident that was unsupervised. If none, she would silence the alarm. Staff O stated they are to check the Kardex before each shift for any changes made. They are also told verbally and there is a binder with the changes as well. She stated she tries to look at the binder every morning unless it is a crazy morning. She also stated her co-workers share the information as well.

In an interview on 10/30/24 at 10:12 AM, Staff P, CNA stated she was involved in an elopement drill last week. Staff P stated if a resident was missing she would check every room to make sure the residents were accounted for. She stated she would first check the room, then the dining area or common areas, go room to room and check everywhere until you find them. If not inside then would move outside. She stated

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everyone was responsible for checking inside and out. She would notify the nurse immediately and then they would move up the line from there. If an alarm goes off, they were to check the call system to see where the alarm was going off. Check that door and check outside. If you did not see anything you were to keep looking. Check every wander guard resident first to make sure they were accounted for first. From there make sure everyone is accounted for. The south door and the and the other main door alarms if the wander guard bracelet gets close to it. But the others just scream until a staff comes to shut it off. If anyone walks through the other doors they go off. Staff P stated is was very important to check outside. They have been told to check the Kardex for updates and all changes are now in red so are easily identifiable.

In an interview on 10/30/28 at 10:28 AM, Staff Q, LPN stated she had worked at the facility for 16 years. Staff Q stated the main entrance by the nurse's station is now closed. The staff received education on alarms and what to do with each type as well and the elopement policy. If a resident was missing, she would gather everyone up front and then divide staff up to search for the resident inside and outside and instruct staff to check everywhere until resident was found. If the resident could not be found then she would alert police that they had a missing resident. She would also let the Administrator, DON the physician know as well. Staff Q stated all alarms needed to be responded to immediately. Staff were to go to the alarm and look outside for anyone who may have left and not just shut it off. Staff Q stated it was everyone's responsibility to go to the alarm. She stated if residents with a wander guards got close to certain alarms they

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go off. There were 2 of these alarms in the facility, the south and the new main entrance. The individual had to be away from the area in order for the alarm to be shut off. The others doors alarm if anyone goes through them, if not silenced first. They have been educated to make sure they are looking at the Kardex to know the updates.

In an interview on 10/30/24 at 10:43 AM, Staff R, Social Services stated she had worked at the facility for 3 months. Staff R stated if she heard an alarm sounding she would immediately find out which alarm was sounding and then would go to that door and if she did not see anybody she would check for all wander guard residents while checking with the team. She stated she would use the WhatsApp to communicate with staff and have request they check for all residents to ensure all are accounted for. Staff R stated it was everyone's responsibility to address alarms if heard.

In an observation on 10/31/24 at 11:35 AM, the surveyor exited the door off the dining room at the end of the 200 hall. There was an immediate response within 35 seconds. Dietary, nursing, maintenance, provisional administrator, social worker and housekeeping all responded and came outside to look who exited the door.

In an interview on 11/1/24 at 12:16 PM, the Provisional Administrator stated it was the expectation staff respond to all alarms and that several staff are attending to each alarm to ensure no residents at risk have left the facility unsupervised. Residents who have a wander guard bracelet were to be checked every 15 minutes to ensure resident safety and all new

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hires were to be educated on what residents are at risk and where the exit doors were in the facility upon hire.

The facility provided policy titled Elopement and Wandering Residents dated 4/19 and last reviewed on 10/24 stated the following:
a. The facility is equipped with door locks/alarms to help avoid elopements.
b. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner.
c. Monitoring and Managing residents at risk for elopement or unsafe wandering:
" Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team.
" The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan.
" Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff.
" Adequate supervision will be provided to help prevent accidents or elopements.
" Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly.
" The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff.
d. Procedure for locating missing resident
" Any staff member becoming aware of a missing resident will alert personnel using facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165350	A. BUILDING _____ B. WING _____	C 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES REHABILITATION AND CARE CENTER	1501 OFFICE PARK ROAD WEST DES MOINES, IA 50265

(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 689	Continued From page 25	F 689		

approved protocol
" The designated facility staff will look for the resident.
" If the resident is not located in the building or on the grounds, Administrator or designee will notify the police department and serve as the designated liaison between the facility and the police department. The administrator or designee should also notify the company's corporate office.
" DON or designee shall notify the physician and family member or legal representative.
" Police will be given a description and information about the resident; include any photos.
" All parties will be notified of the outcome once the resident is located.
" Appropriate reporting requirements to the State Survey agency shall be conducted.

The Provisional Administrator reported the steps the facility took to prevent future elopement events:
a. The social services designee will educate all new hires on elopement, wandering, and resident safety.
b. All exit doors will be checked daily for 30 days to ensure use and functions
c. The main entrance was moved to the 1499 door, and receptionists were placed in front of it. The old entrance door is no longer the main entrance and is locked per fire safety regulations. Visitors are encouraged to use the new entrance to ensure resident safety and monitoring.
d. IDT doing Guardian Angel rounds to help with residents' quality care and resident safety checks. Started on 10/22/24.
e. The Corporate Nurse and Regional Director of Operations conducted a Root Cause Analysis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(RCA) on all risk management from the previous 90 days. Current residents impacted by the RCA findings had safety measures and resident-specific interventions added to their care plans. Changes to the care plans were also updated on Kardex.
f. The Corporate Nurse then educated the DON on the Fall Preventions Program, all facility fall-related policies, how to conduct an RCA, and how to ensure timely and complete incident investigations.
g. The DON or designee educated all staff on facility Fall Preventions Program guidelines, following care plan/Kardex interventions, and all facility fall-related policies.
h. The DON or designee will audit new admissions daily to ensure the completion of the Fall Risk Assessment Tool and that risk factors, safety measures, and resident-specific interventions are reflected in the care plan and updated on Kardex.
i. The DON or designee will review all falls at the daily stand-up meeting with the IDT for 3 months to ensure appropriate fall interventions are implemented, the resident's care plan has been reviewed and revised, and the Kardex has been updated.

PINE ACRES
REHABILITATION AND CARE CENTER

This serves as the credible allegation of compliance for Pine Acres Nursing and Rehabilitation. We assert that all correctives described on this plan of correction have been implemented. In regard to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of actions. The staff of Pine Acres Nursing and Rehabilitation is committed to delivering high quality healthcare to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that Pine Acres Nursing and Rehabilitation is in substantial compliance as set forth below. We are confident that we will be found in substantial compliance upon resurvey. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. Pine Acres Nursing and Rehabilitation has completed the following interventions due to the survey's findings exiting 10/31/2024. The facility will be in substantial compliance by 11/17/2024.

F689 Free from Accidents and Hazards

Immediate Corrective action:

1. The MDS coordinator reviewed section E of the MDS and associated CAA. Care plans were reviewed and updated to reflect the audit findings
2. Resident #1 is no longer a current resident of the facility.
3. Appropriate revisions were made to Care Plans and wander guards were checked for appropriate functioning.
4. All doors were immediately checked for proper functioning, and no concerns were identified.
5. Appointment made to outside company to have alarms inspected on 10/23/24 no issues identified.
6. Immediate education with all staff provided on the elopement and wander guard policy on 10/23/24.
7. The IDT team ensured that all residents identified as “at risk” for falls had safety measures and resident-specific interventions added to their care plans.
8. The DON or designee will audit all new admissions for elopement risk and ensure interventions are in place.
9. On 10/24/24, the IDT reviewed the most recent fall risk assessments for all residents identified as potentially at risk for falls. Residents determined to be at risk have completed care plan updates, and the interventions currently in place are appropriate.
10. The IDT team ensured that the safety measures and resident-specific interventions added to the care plans were also reflected on Kardex so that the CNAs had access to this information in both POC and Kardex.
11. The DON and designee(s) instructed the CNAs to review the updated Kardex before their next shift.

Identification of Residents Affected or Likely to be Affected:

On or before 10/31/24 The IDT (Interdisciplinary team) reviewed all residents and re-evaluated those that were at risk for elopement. Residents determined to be at risk their Care plan updates are complete and interventions that are currently in place are appropriate.

Actions taken/systems put into place to prevent future occurrence include:

1. The social services designee will educate all new hires on elopement, wandering and resident safety.
2. The main entrance was moved to 1499 door, and receptionists were placed in front of it.
3. IDT team do Guardian Angel rounds to help with resident's quality care and resident safety checks.
4. The DON or designee educated all staff on facility Fall Prevention Program, all facility fall-related policies, how to conduct an RCA, and how to ensure timely and complete incident investigations.
5. The DON or designee will audit new admissions daily to ensure the completion of the Fall Risk Assessment Tool and the risk factors, safety measures, and resident-specific interventions are reflected in the care plan and updated on Kardex.
6. The DON or designee will review all falls at the daily stand-up meeting with the IDT for three months to ensure appropriate fall interventions are implemented, the resident care plan has been reviewed and revised and the Kardex has been updated.

How the corrective action will be monitored:

1. The nursing management team will review each incident report upon occurrence to ensure appropriate interventions are implemented and the plan of care is updated. The Director of Nursing (DON), or designee, will complete 5 random weekly chart audits for six (6) consecutive weeks then 2 random weekly chart audits for six (6) consecutive weeks and review all fall incident reports to ensure that appropriate interventions have been put in place to reduce the risk of resident falls/accidents and that care plans have been updated to reflect these interventions.
2. The nursing management team will review each incident report upon occurrence to ensure appropriate interventions are implemented and the plan of care is updated. The Director of Nursing (DON), or designee, will complete 5 random weekly chart audits for six (6) consecutive weeks then 2 random weekly chart audits for six (6) consecutive weeks and review all residents "at risk" for elopements and update assessments as needed.
3. Audit results and additional corrected action will be reported and discussed in QAPI and further corrections in the monthly meeting for 6 months or until sustained compliance is achieved.
4. All exit doors will be checked daily for 30 days to ensure proper use and function.

Corrective action completion date: 11/17/2024.