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	165161	A. BUILDING _____ B. WING _____	C 05/26/2022

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	F 000		
✓	Correction date: 6/17/22			
	A complaint survey conducted 5/10/22 - 5/26/22 related to the investigations of #103944-I and #104618-C resulted in the following deficiencies. Facility reported incident #103944 was substantiated. Complaint #104618 was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Sayler
TITLE: Administrator
(X6) DATE: 6/17/2022

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

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F 580	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, family, staff and provider interviews, the facility failed to notify the family and/or the physician of a resident's elopement, unwitnessed fall and the initiation of Physical Therapy/Occupational therapy for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 53 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated 4/3/22, documented a Brief	F 580	Action 1. Staff members educated on policy at time of survey, additional follow up education to staff regarding policy on any accident, injury, or adverse change of condition and notification to residents point of contact will action item for staff meeting 6/24. 2. Upon each incident entered, verification by DON and Administrator is needed to sign off in Point Click Care under Risk Management. 3. Audits will be completed on all incidents to ensure that appropriate family, requesting parties and physicians are completed timely. 4. DON or designee will audit these incidents x3 times weekly. Results of audits will be documented for 3 months for adherence to the regulation and reported monthly to QAPI to increase/decrease frequency as needed. Initiation of Physical Therapy/Occupational Therapy. 1. Orders received by nursing staff, entered into Point Click Care. Orders are also verified by Therapy. 2. DON or designee will run/review new order reports in Point Click Care x3 weekly and additionally as needed. 3. DON or designee will audit for documented communication to residents point of contact was complete with each new therapy order or change. 4. Results of audits will be documented for 3 months for adherence to the regulation and reported monthly to QAPI to increase/decrease frequency as needed.	6/17/2022

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Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The MDS documented Resident #1 required supervision and set up help only in transfers, walking in his room, walking in the corridor, or locomotion within the facility. The MDS documented Resident #1 as unsteady, but able to stabilize without assistance. The MDS documented the resident required limited assistance in toileting, and able to stabilize without staff assistance. The MDS identified a mobility aid as a walker. The MDS included diagnoses of diabetes mellitus, non-Alzheimer's dementia, an anxiety disorder, unspecified behavioral, and personality disorders.

Resident #1's Care Plan review
a. The Focus Area dated 4/14/22 regarding behavior/elopement risk. The included goal documented Resident #1 wouldn't wander to places in the facility that were unsupervised and he would stay in the building unless a staff member went with him. The Focus area included an intervention revised 1/27/22 that indicated Resident #1 used a wanderguard (device that can alert alarms when/where installed on exits).
b. The Focus Area dated 12/29/20 related to his risk of falls. The Focus area included a goal to safely ambulating within the facility. The included interventions revised:
i. 1/27/22 directed the staff to ensure that Resident #1 was not barefoot with transfers and ambulation.
ii. 4/3/22 check on Resident #1 approximately every one hour during the night.
c. The Focus area dated 12/29/20 related to transfers, bed mobility, and ambulation with a goal to be safe in all his movements. The Focus included the following interventions,
i. revised 10/7/21 directed that Resident #1

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could walk independently with transfers and ambulation, but he could be unsteady at times.

ii. revised 10/7/21 directed the staff to offer assistance and directions to Resident #1 due to his cognition getting worse.

The Incident Report dated 4/3/22 at 8:00 AM documented that Resident #1 reported that he fell during the night and hit his head on the floor. The nurse noted two skin tears to the top of his left hand measuring 0.4 centimeters (cm) and 0.6 cm. Resident also had a hematoma to his left side of his head measuring 4 cm. The family and physician received notification on 4/3/22 at 11:47 AM.

The Incident Report dated 4/19/22 at 8:30 AM indicated the staff heard a garbage fall over and ran into Resident #1's room. The staff noted Resident #1 laying on the ground in front of his toilet with a garbage can beside him. Resident #1 had his socks, shoes, and glasses on. Resident #1's pants were around his knees with a pullup brief. No injuries noted at the time. Resident #1 told the staff that he was sitting on the toilet and leaned forward then fell. The facility notified the physician on 4/19/22 at 3:06 PM and his family on 4/19/22 at 2:39 PM.

The Incident Report dated 4/30/22 at 10:10 AM documented that the staff found Resident #1 getting up off the floor using his side table for leverage. Resident #1 wore socks, shoes, and glasses. Resident #1 told the Certified Medication Aide (CMA) that he fell and hit his left side of his head but didn't get hurt. The facility notified the physician on 4/30/22 at 3:06 PM and his family on 4/30/22 at 2:50 PM.

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On 4/11/22 at 9:58 AM the Director of Nursing (DON) documented that Staff F, Registered Nurse (RN), notified Resident #1's family and physician regarding his elopement on 4/10/22.

On 5/11/22 and 5/18/22, phone interviews with the Attending Physician's Assigned Nurse (APAN), revealed they had no record of any facility calls or faxes regarding Resident #1's falls on 4/3/22, 4/19/22 and 4/30/22. The APAN stated the office had no call or fax record related to Resident #1's elopement on 4/8/22.

A fax to the physician dated 4/26/22 documented a request for an order for Physical Therapy and Occupational Therapy (PT/OT) to evaluate and treat Resident #1, due to low back pain, strengthening, and decreased balance. The Physician replied yes to the order on 4/30/22 and the facility noted the order on 4/30/22.

The Nurse Progress Note dated 4/30/22 at 1:55 AM indicated the facility received a signed fax back from the physician with orders for PT and OT to evaluate and treat for low back pain, decreased balance, and strengthening.

On 5/17/22 at 3:00 PM, Staff F revealed she received instruction to notify the family, by the previous Administrator, on 4/10/22 at 2:30 PM. Staff F stated she was "upset" with the request, as she didn't work on 4/8/22 PM, when Resident #1 eloped. Staff F reported that she felt uncomfortable without knowing firsthand about the incident. Staff F stated she was aware that Staff G had come into the facility at that time to finish up on some documentation. Staff F thought Staff G would make the notification, as Staff G was the nurse working on 4/8/22 during the

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elopement.

On 5/11/22 at 2:50 PM, in a phone interview with Staff G, she reported that she didn't notified the resident's family or physician, as she was unsure of the elopement policy and expectations. Staff G explained that she didn't have a conversation or guidance from the previous Administrator when he came to the facility on 4/8/22 at 8:27 PM, per the facility's self-report to the Iowa Department of Inspections and Appeals (DIA). Staff G added that another staff member notified the DON upon the resident's return to the facility on 4/8/22 at 8:08 PM. Staff G said she thought the DON must have notified the administrator.

On 5/16/22 at 8:00 AM, in a phone interview with the resident's emergency contact, POA (Power of Attorney), confirmed she had only been contacted by the facility regarding the falls on 4/3/22 and 4/30/22. The POA expressed that at no time did any family member receive notification of her father's elopement from 4/8/22, nor the fall of 4/19/22. The POA reported that no family member got notified or consulted of the request and initiation of PT/OT services on 4/26/22.

On 5/18/22 at 5:10 PM, during a joint review of the clinical record, the DON stated that she expects nursing staff to follow facility policy including notification of the resident's attending physician and family of changes in condition, changes in status, changes to treatment and incidents including falls and elopements. The DON stated she expects these notifications to be included in the clinical record including progress notes and scanned copies of faxes sent to physician's offices.

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F 580	Continued From page 6 The Change in a Resident's Condition or Status policy dated 10/17, identified the purpose of the policy as to insure proper, timely reporting, and documentation of any changes in a resident's condition or status. The policy directed staff to notify the resident's attending physician and the resident's responsible party when an accident or incident involved the resident. The policy recorded that except in emergencies, notifications would be made within 24-hours of a change occuring in the resident's condition or status. The Assessing Falls and Their Causes policy dated 1/1/16, identified falls as the leading cause of morbidity (specific illness or condition) and mortality (death) among the elderly in nursing homes. It directs staff to notify the resident's attending physician and family in an appropriate time frame, then document the notification. The Accident-Incident-Elopement-Wandering Resident policy dated 1/22, identified the purpose as to identify residents at risk for wandering and/or elopement and to provide a mechanism to ensure the safety of all residents. The policy directs staff to notify the attending physician and Resident's Responsible Party or POA of the incident of any missing resident and upon their return to the facility, and to make appropriate entries in the medical record.	F 580		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		

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This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility skill competency review, and staff interviews, the facility failed to provide incontinent care and treatment consistent with the residents Care Plan and professional standards of practice, for 1 of 3 residents reviewed (Resident # 3). The facility reported a census of 53 residents.

Findings include:

Resident #3's Minimum Data Set (MDS) dated 4/25/22 identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The MDS documented Resident #3 required extensive assistance of two persons with bed mobility, toilet use, personal hygiene, and transfers. The MDS documented Resident #3 had an indwelling urinary catheter in place. The MDS recorded Resident #3 as always incontinent of bowel and didn't have a toileting program. The MDS included diagnoses of heart failure with coronary heart disease (CAD) (insufficient blood flow to the heart muscle), diabetes mellitus, renal insufficiency (decreased kidney function), chronic obstructive pulmonary disease (restricted airflow in lungs) with an anxiety and depressive disorder.

The Care Plan, dated 4/27/22, identified a focus area of risk for pressure ulcers. The included goal documented to maintain intact skin. The Care Plan directed staff to complete perineal care after each incontinent episode.

The undated Certified Nursing Assistant Competency Checklist: Skill 22 Perineal Care directed staff to assemble the necessary

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F 677	Continued From page 8 equipment: a basin for water, soap, towels and washcloths. The further instructed to wash the entire perineal area with a soapy washcloth, moving from front to back, using a clean area of the wash cloth or a clean washcloth for each stroke. On 5/18/22 at 5:47 PM, Staff C, Certified Nurse Aide (CNA), reported she observed Staff D, CNA, using paper towels with a basin of water to provide pericares to Resident #3. Staff C explained that Staff E, CNA, intervened for Resident #3 and provided Staff E disposable pre-moistened cloths. On 5/19/22 at 2:50 PM, Staff E confirmed that she had observed Staff D preparing to clean Resident #3 of stool and told her that she couldn't do that. Staff E added that she went to the unit supply room and returned with pre-moistened disposable cloths. Staff E then assisted Staff D provide Resident #3 with perineal cares. Staff E reported that the supply room had approximately one dozen packages of wipes in the supply room at that time. On 5/19/22 at 3:00 PM, Staff D confirmed that she prepared to use paper towels to clean Resident #3 due to her being incontinent of stool. Staff D explained that she realized that once she positioned Resident #3 on her side, that she didn't have pre-moistened cloths to complete the cares. Staff D explained that used paper towels before when she ran out, because she wasted so many steps and time going to get supplies. On 5/19/22 at 3:20 PM, the Director of Nursing/Infection Preventionist (DON/IP) stated she expected staff to utilize the facilities	F 677	Action 1. Staff member educated on appropriate perineal care and policy reviewed 6/14/22. 2. Additional and follow-up education to be provided/reviewed at monthly staff in-service as an action item regarding policy 6/24/22. 3. DON or designee will audit x2 weekly for 2 months with staff to ensure providing appropriate perineal care. 4. Results of audits will be documented for 2 months for adherence to the regulation and reported monthly to QAPI to increase/decrease frequency as needed.	6/17/22

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F 677	Continued From page 9 packaged, pre-moistened cloths for all incontinent cares for residents. The DON/IP planned to reeducate staff on the standards of care. The DON/IP expressed that the use of paper towels was unacceptable.	F 677		
F 689 SS=K	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 record review, observations, interviews with staff and residents, the facility failed to adequately analyze the environment and implement measures to reduce the risks of wandering and elopement, as much as possible, and lacked sufficient supervision to detect elopement, for 1 of 3 residents reviewed (Resident #1) as an elopement risk. Resident #1 exited the facility through an unoccupied hall. The facility staff failed to notice that Resident #1 left the facility until another resident noticed him outside of her window. Due to the location of the facility and the lack of staff awareness, this resulted in a potential for Immediate Jeopardy for residents at risk of wandering. The facility reported a census of 53 residents. Findings include: Resident #1's Minimum Data Set (MDS)	F 689	Action 1. Door alarms in Daisey Lane have been updated and reconfigured with audible notifications on 5/16/22. Audile alarms physically on the door and door notifications updated in call system to notify when outside exit door alarm is activated it is an audible notification in the call system to alert staff appropriately. 2. Staff educated completed on Daisey Lane door alarms on 5/16 & 5/17. 3. Maintenance or designee will continue to check and audit alarm functionality and appropriately document findings. 4. Maintenance or designee will provide alarm functionality documentation to Admin or designee for review which will be audited x3 weekly for 3 months to ensure alarm functionality 5. Results of audits will be documented for 3 months for adherence to the regulation and reported monthly to QAPI to increase/decrease frequency as needed.	6//17/22

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assessment dated 4/3/22, documented a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The MDS documented Resident #1 required supervision and set up help only in transfers, walking in his room, walking in the corridor, or locomotion within the facility. The MDS documented Resident #1 as unsteady, but able to stabilize without assistance. The MDS documented Resident #1 required limited assistance in toileting, and able to stabilize without staff assistance. The MDS identified a mobility aid as a walker. The MDS included diagnoses of diabetes mellitus, non-Alzheimer's dementia, an anxiety disorder, unspecified behavioral, and personality disorders. The MDS documented that Resident #1 didn't display behaviors, including aggression, rejection of cares, or wandering.

Resident #1's Care Plan review
a. The Focus Area dated 4/14/22 regarding behavior/elopement risk. The included goal documented Resident #1 wouldn't wander to places in the facility that were unsupervised and he would stay in the building unless a staff member went with him. The Focus area included an intervention revised 1/27/22 that indicated Resident #1 used a wander guard (device that can alert alarms when/where installed on exits).

The Facility Self-Report submitted on 4/9/22 documented that staff saw Resident #1 on the security cameras entering Daisy Hall through an unsecured, closed interior fire door at 7:34 PM. The report described Resident #1 observed on outside camera in the service area parking lot on the west side of the building. The camera viewed Resident #1 as proceeding south, back towards the Daisy Hall exit at 7:35 PM. The next viewing

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of Resident #1 documented at 7:39 PM walking past a smoking patio on the southwest portion of the building, heading southeast. The report documented Resident #1 viewed on the camera, approached by staff, and led back into the facility at 7:40 PM.

On 5/10/22 at 1:20 PM, an outside walking tour was conducted with the Plant Operations Director. Outdoor camera locations identified at the service entrance, the northeast and around the corner of the building from the Daisy exit, and a second camera located southeast from the Daisy wing, at the enclosed smoking patio, outside the adjoining Cherry Blossom wing. The Plant Operations Director identified no other outside cameras located on the southern portion of the facility. The tour revealed grass pie shaped areas between the southern wings (Aspen wood, Bayberry, Cherry Blossom, and Daisy Lane) (A, B, C, and D wings/halls). The southern area of the facility abuts (next to or have a common boundary with) a steep, undeveloped wooded slope that goes downwards to a busy residential street with a 30 mile per hour (mph) speed limit. Observed paved sidewalks connecting the Halls D, C, and B. Outside of the connecting B and A halls lacked a paved path, the area observed to be a grassy area with uneven terrain.

The Resident Listing Report printed 5/10/22 indicated four residents at risk for wandering with a BIMS score 12 or less, indicating moderate to severe cognitive impairment, and could transfer independent in the facility.

On 5/10/22 at 12:17 PM, Resident #1 explained that he had no recall of the elopement on 4/8/22. Resident #1 claimed he was content at the facility

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and offered that he wasn't as sharp as he once was. Resident #1 could recall a recent fall where he bumped his head. Resident #1 demonstrated remote recall in sharing details of his career as a plumber for a local company, his positive relationship with the employer, and talked at length of his past hobby of building racing motorcycles with his son.

On 5/11/22 at 11:00 AM, Resident #1's Power of Attorney (POA) revealed that she didn't get informed by the facility that he eloped on 4/8/22. The POA expressed concern with the lack of communication and said that there had been numerous management changes at the facility. The POA explained they just didn't know her Dad that well.

On 5/11/22 at 2:50 PM, Staff G, Registered Nurse (RN), explained that she was working in the A hall and heard the exit alarms two to three times, but she thought it was from the exit door in C hall. Staff G reported it was around the time the residents went out to smoke. Due to the timing she believed the sound came as a result of the staff taking the residents outside the C hall door to the smoking patio. Staff G commented that upon Resident #1's return inside the facility, she realized she heard the B hall exit alarm as staff used that exit to search outside. Staff G added that she documented a brief progress note upon Resident #1's return and noted no injuries at 6:50 PM on 4/8/22. Staff G confirmed that she didn't notify the family or physician. Staff G reported that she had no contact with the Administrator that came to investigate the elopement. Staff G said she believed Staff I, Certified Medication Aide (CMA), initially contacted the Director of Nursing (DON) and notified the family. Staff G

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declined knowing if the alarm sounded in Daisy hall's exit.

On 5/11/22 at 1:40 PM, Staff I, explained that she got approached by Resident #2 while in the B hall, who stated that she saw Resident #1 outside her room's window. Resident #2 explained that she saw Resident #1 on the sidewalk between the B and C halls. Staff I explained that she pulled the stop sign banner, connected to the door frame with Velcro, down and exited the B hall exit door. Once outside she began to search the area. Staff I reported that she initially went towards the C and D halls. After she didn't see Resident #1, she then turned around and searched the area between A and B halls. Staff I added that she encountered Resident #1 accompanied by Staff J, Certified Nurse Aide (CNA), as they entered the facility through the B hall exit.

On 5/11/22 at 1:45 PM Staff K, CNA, stated she was working in the C hall, when Resident #2 reported that she saw Resident #1 outside her room window. Resident #2 reported that she saw him walking on the sidewalk with his walker between the C hall and B hall. Staff K reported that she exited the front entrance of the facility, as she heard the exit alarm sounding. Staff K added that she thought the delivery from pharmacy set off the alarm because she encountered them in the hallway. Staff K reported that she returned to the A hall after she silenced the alarm. Staff K expressed that she got informed that Resident #1 went outside. Staff K feared that he exited from the front door, so she went out the front door exit to search for him. Staff K explained that she headed north around the facility, then headed to the southwest service area, and the exit from Daisy hall. Staff K confirmed that she didn't hear

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any alarms from the D hall exit. Staff K explained that she encountered Staff J who told her Resident #1 was not in the area of D and C hall courtyards. Staff K added that she turned around, went to the front of the facility, and rounded towards the A hall exit. At that point she encountered Staff I, Staff J, and Resident #1. Staff K reported that Resident #1 had been located standing next to the other resident's windows in the A hall courtyard. Staff K declared that she followed Staff I and Staff J with Resident #1 inside the facility using the Hall B exit. Staff K explained that Resident #1 was cooperative and appeared uninjured. Staff K reported that Resident #1 wore a t-shirt, sweatpants, and blue gripper socks. Staff K confirmed she only heard the B hall exit alarm during the search.

On 5/12/22 at 2:45 PM, Staff J stated that she worked in the A hall and Resident #2 told her that she saw Resident #1 outside her window, walking on the sidewalk. Staff J added that she went outside through the B hall exit. Staff J reported that she thought the Velcro stop sign banner was already pulled down. She couldn't recall if she heard the alarm sounding. Staff J explained that she saw Staff I in the courtyard area between the B and C halls, so she went to the courtyard between the A and B halls. Staff J confirmed that she found Resident #1 standing near birdfeeders and a resident's window, outside of A hall in the courtyard side. Staff J explained that Resident #1 had his walker, he wore a t-shirt, sweatpants, and blue gripper socks. Staff J added that Resident #1 seemed his typical confused self. Staff J reported that Resident #1 appeared uninjured and acted cooperative with the staff. Staff J said they returned inside the facility through the B hall exit, accompanied by Staff J and Staff I.

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On 5/12/22 at 7:20 AM Resident #2, reported that she saw Resident #1 outside her window, between B and C halls. Resident #2 explained that he walked on the sidewalk, and kept looking around. Resident #2 stated it was approximately 6:30 PM and 'knew he shouldn't be out there alone at that time. Resident #2 explained that she didn't recall if Resident #1 had his walker with him. Resident #2 reported that she went out into hallway and located Staff I. After finding Staff I, Resident #2 informed her that she saw Resident #1 outside her window. Resident #2 explained that Staff I exited the B hall door. As Staff I exited the door, she heard the alarm sound. Resident #2 said that she went to the commons area, where she saw Staff J and informed her about Resident #1. Resident #2 commented that she believed Staff J also exited the B hall door. Resident #2 explained that she believed it took approximately three minutes to locate and tell Staff I at first, then approximately ten minutes for her to see Resident #1 returned to the facility. Resident #2 declined that she had contact with the previous Administrator when he arrived at the facility to investigate.

On 5/11/22 at 9:00 AM, the Iowa State Climatologist reported the temperature for 4/8/22 at 7:30 PM was 47 degrees Fahrenheit with winds from the north at 18 mph and gusts to 35 mph. This created a wind-chill factor of 40 degrees Fahrenheit. The Iowa State Climatologist stated it was a cloudless night without precipitation.

On 5/11/22 at 7:45 AM, the Administrator, stated the cameras only retained two weeks of video memory before it got automatically erased, thus the facility no longer had video from the night of

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the elopement on 4/8/22. The Administrator showed the display on her computer monitor, with 4/26/22 as the last available date saved.

On 5/11/22 at 9:30 AM, during a joint review of the clinical records with the Director of Nursing, DON, she confirmed that she couldn't provide any fax notifications to Resident #1's attending physician related to his elopement. The DON stated that she expected the nursing staff to inform the family and the physician of elopement incidents.

During a follow-up interview on 5/12/22 at 3:30 PM the DON, reviewed the undated document titled "Elopement Prevention POC" submitted by the previous Administrator included with the 4/9/22 facility self-report to IDIA. The DON confirmed the plan directed the staff to perform resident location checks every two hours until further notice and to conduct fire door checks every 15 minutes until further notice. The DON denied knowing when the previous Administrator decided to discontinue the checks. During a joint review of the documented resident checks labeled for Aspenwood, the DON noted the night shift provided documentation every 2 hours, with the last entry at 6:00 AM on 4/16/22. The review determined no documentation for the day shift and only two evening shifts documented checks for Resident #1 on 4/8/22 and 4/9/22. The Cherry Blossom documentation revealed that the night shift ceased documenting at 6:00 AM on 4/16/22. The review lacked day shift documents and only one evening shift document dated 4/10/22. The Bayberry resident checks were labeled as Resident #1 checks. The checks had incomplete documentation for the dates of 4/10/22, 4/11/22, 4/12/22 with the last recorded entry at 10:00 PM

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on 4/12/22. The documentation related to the fire door being checked every 15 minutes covered the dates of 4/8/22 thru 4/18/22, with often one staff member's initial at the top of a column, followed by a line thru multiple time entries. The DON declined knowing of any resident count exceptions given to the day or evening shifts, The DON confirmed that she had no other resident check logs or documentation to provide. The DON verified Daisy hall was not occupied by any residents at the time and date of the elopement. The DON explained they reserved that hall for COVID-19 positive, suspected positive residents, and new admission quarantines. The DON reported that she expected resident location checks be completed and include all shifts, unless specified differently.

On 5/11/22 at 8:27 AM, a joint audit conducted with the Plant Operations Director of the alarm system for Daisy hall determined the magnet alarm added to the interior fire doors, following the elopement on 4/8/22 on the Daisy hall, did not alarm when opened. The Plant Operations Director entered the activation code and then the alarm sounded when opened. The Plant Operations Director said the alarm system got checked every morning. He reported that Staff L, Plant Operations Staff, checked the alarm earlier that morning. The Plant Operations Director explained that staff or housekeeping turned off the alarm if they enter the hall. The Plant Operations Director added that they probably forgot to reactivate it.

The undated Elopement Prevention POC (Plan of Correction) added installation of alarms on the double fire doors at the Daisy, South and North Doors on the Front Hall on 4/9/22.

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The Facility's Daily Door Alarm, Wander Guard, and Maglock checks lacked documentation of the four magnet alarms installed on 4/9/22 until 5/12/22.

On 5/11/22 at 8:35 AM Staff L, stated he checked all alarms earlier in the day at 8:00 AM. He noted the magnet alarm to Daisy hall didn't alarm when he checked it. Staff L explained that he reset it at that time and believed the alarm to be functioning.

On 5/12/22 at 9:00 AM, the Plant Operations Director stated the additional four magnet door alarms were added to the Daily Alarm Checklist. The Daily Alarm Checklist included Daisy hall, 2 dining room exits, the north and south doors to the entry of the main hallway.

On 5/11/22 at 10:00 AM, rounds completed with the DON to audit the eight residents Care Planned identified as at risk for wandering and care planned for wander guard bracelets. The audit revealed all identified residents at risk for wandering/elopement to have functioning wander guards in place on their wrists.

During a follow-up on 5/11/22 at 10:35 AM the DON, stated she expected the door alarms to be active and operating on Daisy hall, unless the Plant Operations Director entered the hall. The DON expected the Plant Operations Director to reactivate the alarm when he exited, after ensuring no resident entered the hall. The north and south fire doors in the main hallway were turned off during the normal office hours due to the staff and the receptionist working in their offices. The DON stated the dining rooms doors

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get activated at the end of the day by the kitchen staff. The DON reported no documentation related to the arming and/or disarming of the added alarms, other than the maintenance checks performed Monday through Friday, when maintenance worked.

During a follow-up interview on 5/10/22 at 1:20 PM, the Plant Operations Director stated the wander guard alarm system linked to the system that transmits alarms to the walkie-talkies and a display screen at the nurses' station. The same system transmits call light notifications when a resident uses their call lights from their rooms or bathrooms. The Plant Operations Director explained that the wander guards create a loud audible alarm located in the alarm box itself. The Plant Operations Director acknowledged that the alarms might not be heard at distant locations in the facility or behind closed doors. The Plant Operations Director added that feature they don't check on. The Plant Operations Director reported the locations of the wander guard alarms as at the Cherry Blossom exit (access to the smoking patio), the service entry on the back of the facility, front entrance, the north exit in the dining room, the north fire doors in main hallway (leads to three non-resident halls on north end of facility) and Ginger Grove hall (assigned to office staff and physical therapy).

On 5/16/22 at 11:00 AM, the Administrator and the DON, said new hire for nursing staff didn't get walkie-talkies assigned to them. They acknowledged that not all staff had possession of walkie-talkies. They reported that the older staff had assigned walkie-talkies. They acknowledged that not all nurses had a walkie-talkie and they didn't have a system in place to know how many

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and which staff had a walkie-talkie on each shift. They reported they had no time line related to changing the current alarm system, walkie-talkies, wander guard alarms, or update the exit alarms to a 14 second delay. They reported the front door as the only door in the facility that after depressing the push bar, the magnet lock doesn't release for 14 seconds. They stated this delayed opening deters a wandering resident to continue to seek to exit thru the door. They reported that the alarm would sound as a secondary alert, if after 14 seconds the key code didn't get entered.

On 5/16/22 at 11:45 AM, an audit of walkie-talkies for all nursing staff on duty identified seven staff on the schedule and on duty. The audit revealed three of the seven staff had walkie-talkies. One staff member reported that she got instructed to turn her walkie-talkie into management over a year ago, and she never got a one re-issued to her. One staff member reported her walkie talkie got loaned to an agency staff over a year ago, and it never got returned. The staff member said she made management aware of the loss, but she didn't get issued a replacement. Another staff member reported she working at the facility for 9 months and never received a walkie-talkie.

A review of the facility policy titled Accident-Incident-Elopement-Wandering Resident, dated 1/22, identified the purpose of the policy as to identify residents at risk for wandering and/or elopement and to provide a mechanism to ensure the safety of all residents. The policy directed that the charge nurse or the DON should notify the attending physician, resident's responsible party, and/or their POA. It further directed nursing to make appropriate

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F 689	Continued From page 21 entries into the medical record. The State Agency informed the facility of the Immediate Jeopardy (IJ) on May 16th, 2022 at 2:30 PM, per phone call, and followed with an email notification with attached IJ template at 2:43 PM. The facility staff removed the Immediate Jeopardy on May 19th, 2022 through the following actions: A. The facility removed the IJ by replacing the magnetic lock with alarm on the fire doors to Daisy Lane hall with a magnetic lock and alarm that cannot be disabled. It allows for a pause and rearms itself in 12 seconds. The alarm is continuous and rated at 100-110 dB (decibels) and similar in volume to the previous alarm. B. The facility assigned walkie-talkies for all of the nurses' medication carts with an additional walkie-talkie in the nurse's station. C. The facility installed a linked magnetic lock to the exit door on Daisy Hall. The alarm connects to the walkie-talkies and voices an alert statement of "Possible elopement Daisy Lane," when opened. D. The facility updated the audio narrative sent to the system that connected with the magnetic locks, to notify of the door location. The system would no longer send a cancel narrative, once the door shut. The scope lowered from a "K" to an "E" at the time of the survey, after ensuring the facility implemented the Daisy exit and fire door alarms, the magnetic lock narrative messaging changes, dedicated walkie-talkies to medication carts, and to the nurses' station.	F 689		
F 836 SS=E	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c)	F 836		

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F 836	Continued From page 22 §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on personnel record review and staff interviews, the facility failed to operate and provide services in compliance with applicable state regulations that require a physical examination and tuberculosis (TB) screening	F 836	Action 1. Education and process updated was provided to Human Resources and Director of Nursing 6/14/22. 2. Review/update current employee charts as needed with examination and TB testing 3. Prior to new hires starting in facility, verify with HR onboarding information is completed, review with Director of Nursing examination and TB screen is completed. 4. Once sign off is received from HR and DON, Administrator will audit employee information to ensure its completeness and notify HR and DON employees start date. This will also coincide with the COVID19 vaccine mandate. 5. These employee onboarding files will be audited x1 weekly by Admin/Designee for 3 months for adherence to the regulation and reported monthly to QAPI to increase/decrease frequency as needed.	6/17/2022

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before employment for 1 of 5 employee files reviewed (Staff C). The facility reported a census of 53 residents.

Findings include:

On 5/17/22 at 10:35 AM, a review of Staff C, Certified Nurse Aide (CNA), employee file revealed the absence of a completed physical examination and TB screening, before her hire date of 8/23/21. The file lacked documentation that the examination or screening ever occurred. An employment checklist included in file revealed the absence of any documentation.

On 5/17/22 at 12:45 PM Staff M, Human Resources Coordinator (HR Coordinator)/Nursing Staff Scheduler, confirmed the personnel file for Staff C lacked the documents verifying a the completion of a physical examination and TB testing before being hired at the facility. Staff M explained that Staff C was a direct hire by the facility, following her work there through a staffing agency.

On 5/24/22 at 1:30 PM, Staff M, indicated the checklist in the employee file as a facility auditing tool developed by the previous Administrator, in response to a previous survey deficiency. Staff M reported that she started her current HR position effective 3/1/22 and had audited employee files as able. Staff M explained that she didn't know if the facility had a policy that addressed employee hiring and file maintenance, but would check.

On 5/25/22 at 10:30 AM, the Director of Nursing, DON, provided a copy of Staff C's previous employer's TB testing record and the Physician Statement of Health, dated 11/11/20. The DON

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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 836	Continued From page 24 confirmed the facility did not update Staff C's TB testing and physician statement of health at her date of hire on 8/23/21. On 5/25/22 at 11:45 AM, the DON, stated she expected facility employees to have pre-hire requirements completed, including statements of physical health and TB screening.	F 836		
F 888 SS=E	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:	F 888		

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F 888	Continued From page 25 (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses	F 888	Action 1. 6/3/2022 – Educated Management staff regarding QSO. Developed plan with HR Coordinator to discuss with unvaccinated staff. 6/7 education for unvaccinated staff started, completed on 6/17. Education to volunteers, contractors and vendors are being provided along with requirements of providing vaccination information for tracking purposes. 2. Staff will have 14 days or sooner from the 6/17 date to provide proof of initial vaccination or provide exemption/accommodation requests. 3. All job postings now indicate the following: "To protect our patients and our staff, Touchstone Healthcare Community requires employees to be fully vaccinated for COVID-19 as a condition of employment, subject to accommodation." 4. Applicants will not be considered if they do not meet the COVID19 vaccine requirement or meet medical or religious accommodations. 5. No employee shall start in their role until they have appropriately completed and have approval for the religious or medical exemption or have met the requirements of the primary series of the vaccine according to the CDC. 6. Employee onboarding files will be reviewed x1 weekly for 3 months and reported monthly to QAPI to ensure staff with proof of vaccine and or religious or medical exemption along with meeting other requirements under F836.	6/17/22

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as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received

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monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;
This REQUIREMENT is not met as evidenced by:
Based on personnel record review, policy review, and staff interviews, the facility failed to meet the Centers for Medicare and Medicaid Services (CMS) guidance of 100% staff vaccination, exemption or temporary delay per the Centers of Prevention Disease and Control (CDC) requirement for Iowa by 3/15/22. The facility provided documentation that 61% of staff were either fully vaccinated or exempted. The facility reported a census of 53 residents, with no current positive resident cases of novel Coronavirus 2019 (COVID-19).

Findings include:

The undated and untitled document provided by the facility on 5/17/22 documented 71 staff. The document included 2 staff no longer employed. The staff list lacked the three recent hires, for a total of 72 active employees. The document identified 44 of the 72 employees as completely vaccinated. The remaining 28 employees out of

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the 72 employees lacked documentation of vaccination or exemption status.

The CMS Memorandum QSO 22-09-ALL dated 1/14/22 documented guidance for the state of Iowa. The guidance instructed within 60 days of the memo Iowa long term care facilities needed the following:
a. 100% of staff that received the necessary doses to complete the vaccine series (i.e., one dose of a single-dose vaccine or all doses of a multiple-dose vaccine series), or were granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC. If the facility could accurately show the requested information, the facility showed compliance under the rule.
b. The Memo proceeded to instruct the following: If less than 100% of all staff have received at least one dose of a single-dose vaccine, or all doses of a multiple-dose vaccine series, or have been granted a qualifying exemption, or identified as having a temporary delay as recommended by the CDC, the facility showed non-compliance under the rule.

On 5/17/22 at 10:35 AM, the Director of Nursing (DON)/ Infection Preventionist (IP), said the facility did not have a COVID-19 testing or vaccination policy, including qualified exemptions and facility contingency plans, for staff or residents.

The DON provided a typed, undated statement, titled "COVID Testing" which instructed unvaccinated staff and residents to be tested on a weekly basis. Further testing would be based on the facility's outbreak status. It documented that further testing may be required based on

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recommendations per Iowa Department of Public Health (IDPH).

The Infection Control Plan policy dated 8/17 directed the purpose of the plan as to provide overall direction to the facility wide Infection Control Plan (ICP). It documents a goal as to decrease the risk of infection of residents and staff. The policy instructed to develop prevention, surveillance, and control measures to protect residents and personnel from healthcare-associated infections. It directed the facility to ensure compliance with local, state, federal regulations related to infection control and accrediting agencies. The policy directed the Administrator as ultimately responsible for the ICP and the DON/IP as delegated responsibility for the daily functions of the ICP.

On 5/19/22 at 12:45 PM, the DON/IP explained that staff testing occurred every Monday. The staff was expected to be tested then, or on the first schedule workday following Monday. The DON/IP reported that the staff testing results got documented on individual forms, the information didn't logged at that time or in an organized manner.

The DON/IP provided a copy of the untitled and undated facility spreadsheet listing staff vaccination and decline status. The DON/IP acknowledged 44 staff were fully vaccinated on the documented dates and 28 staff had no documentation of COVID-19 vaccinations or exemption status. The DON/IP said the staff vaccination, exemption tracking, documenting, and enforcement had not been a priority for her. The DON/IP acknowledged the facilities current decline option offered employees, was not in

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F 888	Continued From page 30 compliance with the CMS guidance for granting staff a qualifying exemption.	F 888		