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	165324	A. BUILDING _____ B. WING _____	C 08/01/2023

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ACCURA HEALTHCARE OF PLEASANTVILLE, LLC	909 NORTH STATE STREET PLEASANTVILLE, IA 50225

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F 000 ✓ ok/cp	INITIAL COMMENTS Correction date: 8/2/2023 The following deficiencies resulted from an On-Site revisit of the survey ending June 29, 2023, investigation of Complaint #113527-C, and Facility Reported Incident #114251-I conducted July 25, 2023 to August 01, 2023. Facility reported incident #114251-I was substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000	The Facility denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility records, resident, family and staff interviews which determined, the facility failed to identify Resident #1 had a risk of elopement and proceeded to exit the facility on 7/10/2023. The front door alarm system failed to engage and the resident left unwitnessed. The resident attempted to leave the facility on 6/26/2023 by exiting the north door of the facility and on 7/3/2023 was exhibiting behaviors of wanting to leave. The facility identified 7 residents with Wanderguards	F 689	In continuing compliance with F 689, Free of Accident Hazards/Supervision Devices, the Facility corrected the deficiency by Executive Director placing back-up alarms on the front doors on 7/10/2023 to ensure an alarm sounds when the door opens. The door alarm system was also placed into "night mode" on 7/10/2023 by the Executive Director to ensure the door alarms each time opened. The wanderguard remains active in night mode. A wanderguard was placed on Resident #1 on 7/10/2023. On 7/18/2023, Resident #1 was moved to the secure memory care unit. On 7/11/2023, all residents were reassessed by Clinical Nurse Specialist or Designee for elopement risk and the elopement book was updated as appropriate to ensure Resident #1 and all like residents are free from risk of elopement. To correct the deficiency and to ensure the problem does not recur, all staff were educated on 7/11/2023 on the missing resident process by the Executive Director. All nurses were educated by the Executive Director by 7/13/2023 on the door alarm check process. The Executive Director and/or designee will perform elopement drills 3 times weekly for 4 weeks, twice weekly for 4 weeks, weekly for 4 weeks, and then as need to ensure continued compliance with the missing resident process. The Executive Director and/or designee will audit door alarm checks 3 times weekly for 4 weeks, twice weekly for 4 weeks, weekly for 4 weeks, and then as needed to ensure continued compliance with monitoring door alarms.	8/2/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Billie [illegible] | TITLE: Administrator | (X6) DATE: 8-18-23

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

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F 689	Continued From page 1 and are at risk for elopement. This circumstance posed Immediate Jeopardy to the resident health and safety. The facility reported a census of 47 residents. The facility was notified of the Immediate Jeopardy (IJ) on July 26, 2023 at 1:00 p.m. The IJ was removed on July 26, 2023. The Facility Staff removed the Immediate Jeopardy through the following actions: 1. On 7/10/2023, back up alarms were placed on the front door to ensure alarms sound when opened. The door alarm system was also placed into "night mode" on 7/10/2023, to ensure the door alarms each time opened. The wanderguard remains active in night mode. A wanderguard was placed on Resident #1 on 7/10/2023. On 7/18/2023, the facility made a male bed open in the secure memory unit and Resident #1 was moved into this bed. 2. By 7/11/2023, all facility staff were educated on the missing resident process. An elopement drill was completed on 7/11/2023 with no concerns. By 7/13/2023, all nurses were educated on the door alarm system. 3. On 7/11/2023, all residents were reassessed for elopement risk and elopement book was updated as appropriate. 4. Immediately after the incident on 7/10/2023, Stanley Healthcare was notified the alarm system malfunction. On 7/12/2023, 7/14/2023 and 7/18/2023, Stanley Healthcare was onsite to investigate the malfunctioned alarm. They determined a new system will have to be installed. The facility continues with twice daily door alarm checks. 5. The facility initiated ongoing audit of the missing resident process via elopement drills three times weekly on 7/11/2023. There have	F 689	As part of Accura HealthCare of Pleasantville's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	

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F 689	Continued From page 2	F 689		

been no issues identified through these audits. The facility also initiated an audit for door alarm checks three times weekly on 7/11/2023, with no concerns noted.
6. Any concerns will be reported to the administrator immediately and addressed in the Quality Assurance.

The scope and severity was lowered from an "IJ" to and "E" at the time of the survey after ensuring the plan of correction was put in place and implemented.

Observation on 7/25/2023 at 1:00 p.m., the facility administrator and this surveyor went to the front doors of the facility and on the north wall of the inside doors was a Stanley Wanderguard Departure Alert System, model #0507-234, with a red light underneath the system a solid color. On the top of the frame on the inside doors were two clip/chair pull away alarms. This surveyor opened the inside door and the wanderguard alert system sounded/alarmed and the two pull away clip alarms were activated. This surveyor and administrator proceeded to open up the door to the outside of the facility, the following were observations on the outside of the facility.
1. Uneven side walk for which was slanted down to the road in front of the facility (north state street), with the edges of the side walk missing pieces of cement.
2. The speed limit sign in front of the facility stated 25 miles per hour.
3. Looking to the south of the facility was a orange sign stating Road Closed ahead, with two orange/white striped barricades across the road with a black sign and orange arrow with DETOUR written on it, and gravel in front of the barricades.
4. Looking to the north of the facility was

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F 689	Continued From page 3 Business Highway 5, with a speed limit sign of 35 miles per hour and a yellow sign with a black curve symbol on it. 5. The facility administrator confirmed and verified that Highway 5 is a busy highway for which there is lots of heavy traffic. Findings include: 1. Resident #1 had a Minimum Data Set (MDS) quarterly assessment with a reference date of 6/29/2023 that documented Resident #1 scored a 4 on the Brief Interview for Mental Status (BIMS) assessment. A score of 4 identified severely impaired cognition and decision making abilities. The MDS identified Resident #1 as limited assistance of one for transfers, walking in room and/or corridor, locomotion on and off the unit and a walker or wheelchair (WC) are used for mobility. The residents diagnoses included Alzheimer's Disease, Non-Alzheimer's dementia, asthma, respiratory failure, repeated falls and osteoarthritis of the knee. Review of Resident #1 Care Plan included the following: Activities of Daily Living (ADL) deficit due to my dementia, and Potential for Behavior/Altered Coping related to: altered mentation and desire to return home at time of admission. Interventions include: * I need assist of 1 for transfers * I need assist of 1 for locomotion * I need assist of 1, walker and gait belt or I use my WC * I use a walker/cane/wc for mobility. * Increased supervision as needed * Provide 1:1 activities as needed * Redirection as indicated	F 689		

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F 689	Continued From page 4 Progress notes dated 7/16/2023 at 6:55 p.m., documented, Note Text: Resident attempted to get out of north door. This nurse stopped resident in which resident states "you have no authority to keep me here!" When this nurse explains why resident is here he states "you're a god damn liar! "get the police here to get me home!". This nurse was able to get resident back to nurses station to by telling him to call his son. He is now talking to his son and seems quite upset. Progress notes dated 7/10/2023 at 8:38 p.m., documented, Note Text: Resident back in facility accompanied by girl friend via personal vehicle. Head to toe assessment completed at this time. Wanderguard activated and applied to residents left wrist. 15 minute checks initiated. Progress notes dated 7/10/2023 at 8:20 p.m., documented, Note Text: Call received from Residents girl friend stating that Resident #1 was dropped off by a black SUV at her house. This nurse explained that staff was unaware of resident getting outside and has not stated anything about wanting to leave facility. Girl friend states she will bring him back to facility. Call placed to on call provider to inform of situation. Call placed to administrator. Progress notes dated 7/10/2023 at 7:33 p.m., documented Note Text: Resident has been up in dining area asking this nurse to call a certain phone number for him stating that it's a friends number. This nurse dialed number and automated system stated phone is no longer in service. This nurse explained this to resident when he asked to have that number dialed again. Resident is not directable at this time and is hyperfocused on that calling that number. This	F 689		

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F 689	Continued From page 5 has continued since 6:00 p.m., when this nurse arrived for this shift. Progress notes dated 7/3/2023 at 2:50 p.m., documented, Behavior Note: for approximately hour after lunch resident up and down halls talking about leaving and trying to make multiple calls to same person. Progress notes dated 6/26/2023 at 8:45 p.m., documented, Health Status Note Text: Resident still at nurses station at this time arguing that he needs to leave. Resident family calling at this time and states resident called them and stated he was outside and was being locked out of the building. This nurse explained that at no time was resident outside of the building, but has been upset that we will not let him leave. Did explain to family that resident did open door to leave, but did not leave the facility. Family not wanting to talk to resident at this time, but seeked clarification. Progress notes dated 6/26/2023 at 8:40 p.m., documented, Health Status Note Text: Resident attempted to exit north side door and difficult to redirect. Resident states "I have to get home! Let me leave!" Resident assisted into w/c and assisted back to nurses station. Staff explained to resident that this is the nursing home and that he lives here. Resident denies this and states he will call the law if we don't let him out. Interview on 7/25/23 at 4:15 p.m., Staff C, Registered Nurse (RN), confirmed and verified that on 7/10/23, Resident #1 was propelling himself up and down the hallway when Staff C got to work at 6:00 p.m., and that the day shift staff explained that Resident #1 was on his roll again wanting to know why he was here. Staff C, kept a	F 689		

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continues eye on Resident #1 during the supper meal and then while the staff were putting residents to bed for which Resident #1 was sitting underneath the television in the dining room and appeared to be sleeping. About 7:40 p.m., staff came and told Staff C that one of the resident had a catheter that was not draining properly and if the nurse could come and check it out. Staff C stated that Resident #1 was still sitting underneath the television in his w/c and that he looked like he was sleeping, Staff C, went down the hallway to the resident room to check on the catheter. Staff C, came back to the nurses station and seen that Resident #1 had moved a little in his w/c from underneath the television. Resident #1 appeared to be calm and content. Staff C went into the nurses supply room to get supplies to flush the catheter and laid eyes on Resident #1 who was still sitting in the w/c. Around 8:00 p.m., Staff C, came out of the resident room walked up to the nurses station to put the supplies away and noticed that Resident #1 was not in the dining room under the TV and no w/c. Staff C, started to walk down the hallway to Resident #1 room when the telephone rang. Staff C answered the telephone, it was Resident #1 girl friend, stating that she had Resident #1 in her car and if she can bring the resident back to the facility. Staff C went to the front inside doors and walked through them and the alarms did not sound. Staff C, stated that the resident returned to the facility around 8:40 p.m. Staff C, called the facility administrator who got to the facility between 8:50 p.m.-9:00 p.m., and placed two extra alarms on the top of the door frame to alert staff that someone was leaving or entering.

Interview on 7/25/23 at 4:55 p.m., Resident #1 girlfriend explained that while watching television

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F 689	Continued From page 7 on 7/10/23, headlights appeared in the drive way around 8:30 p.m., she got up and proceeded to go out to the driveway and by the time she got out to the driveway, a black SUV had already assisted Resident #1 out of the vehicle and was backing out of the drive way and Resident #1 was in his wheelchair. The girl friend went and assisted Resident #1 in her vehicle, proceed to call the facility and returned Resident #1 to the facility. Interview on 7/25/23 at 11:20 a.m., the facility administrator explained that on 7/10/23, she got a telephone call from Staff C, RN around 8:40 p.m., that Resident #1, girl friend was bringing back the resident to the facility, that a couple in a black SUV came up into the girl friends drive way and assisted the resident out of the vehicle, put the resident into his w/c and then left. The administrator got to the facility between 8:50-9:00 p.m., went to the inside door of the facility and it was beeping and the light was flashing orange (for which means the alarm is not in activation mode). The administrator put in the code to reset the alarm and the light on the wanderguard system went to red, for which meant it was activated, for extra safety measures two clip/chair alarms were put on the frame on top of the front doors to ensure that the door alarms sounded if opened again. Interview on 7/26/23 at 9:15 a.m., Staff A, Certified Nurses Aide (CNA) and Staff B, CNA, confirmed and verified that on 7/11/23 at 6:00 a.m., they both came to work and the front door wanderguard alarm system was beeping and they stated that every once in a while when the generator or a surge would happen the alarm system would beep and that would signal that the	F 689		

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F 689	Continued From page 8 wanderguard alert system needed to be reset, so they went over to the alarm and unplugged the system from behind the desk, waited a few seconds and plugged the alarm system back in and entered the code and the alarm system light went to a solid green, letting them know that the alarm system was activated. They confirmed and verified that the alarm system will continue to beep until you put in the code or unplug the alarm system to reactivate the wanderguard alert system. Interview on 8/1/23 at 11:00 a.m., Resident #1 denied leaving the facility at anytime and that if he did leave the facility he would of remembered being outside. Interview on 7/26/23 at 1:30 p.m., the facility administrator stated that the facility lacked a policy/procedure on how often to check the door alarms to make sure they function, but the expectation is for the staff to check the door alarms every shift and document on the Monthly Door Alarm log.	F 689		