STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165440	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINSLOW HOUSE CARE CENTER	**3456 INDIAN CREEK ROAD MARION, IA 52302**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews and observations the facility failed to provide adequate supervision to prevent the elopement of 1 of 7 sampled residents (Resident #1). The facility reported a census of 42. Findings include: According to the Minimum Data Set ((MDS) dated [DATE] Resident #1 documented with [DIAGNOSES REDACTED]. The resident had a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive ability. The resident required limited assistance of 1 staff for transfers, ambulation and extensive assistance of 1 staff for personal hygiene. The resident utilized a walker and wheelchair to move about the facility. Review of Resident #1's Care Plan dated 6/18/20 the resident experienced wandering behaviors and directed the staff to assure proper fitting footwear, redirect from the exit doors as needed and to place a wanderguard on the resident. Review of an Incident Report dated 8/3/20 at 6:00 p.m., revealed at 6:00 p.m. Staff A, Registered Nurse (RN) came to work and noted Resident #1 outside on the sidewalk in front of building alone. Staff A called the facility to inform the staff she found the resident outside. The report indicated the staff completed a full assessment, no injuries noted. The staff placed the resident on 15 minutes checks. During an interview on 8/12/20 at 10:26 a.m., Staff A stated when she pulled up to the building at approximately 5:47 p.m. for her shift she noted Resident #1 walking alone in front of the building. Staff A called to the facility and reported the resident outside and to bring a wheelchair for her. Staff A stated she did not hear the alarm sounding when she called into the facility and did not hear alarms ringing when Staff C, RN opened the door to retrieve the resident. During an interview with all staff working on 8/5/20 between 5:30 p.m. and 6:00 p.m. revealed the following: a. During an interview on 8/11/20 at 11:43 a m., Staff B, Licensed Practical Nurse (LPN) stated she was on the east hall passing food trays to the residents on that hall, she did not hear the alarm sound and did not turn off the alarm. b. During an interview with Staff C, RN on 8/13/20 at 1:28 p.m., she stated she was on the north hall passing ice cream treats to some residents, she did not hear the alarm and stated she did not turn it off. c. During an interview with Staff D, Certified Nurse Aide (CNA) on 8/11/20 at 3:00 p.m. stated she was assigned to Resident #1 that evening but at the time the resident eloped from building she was in a resident room on the south hall, door closed, providing cares to another resident. Staff D stated earlier in shift Resident #1 noted to be walking in the hall but did not exhibit exit seeking behaviors. Staff D stated she did not hear the door alarm sound. d. During an interview with Staff E, CNA on 8/12/20 at 2:30 p.m., Staff E she was in the shower room with another resident. The aide heard a door alarm sound but had another resident in the shower room that could not be left unattended. Staff E put her head out the shower room door but did not see staff or residents in the area. e. During an interview on 8/11/20 at 2:00 p.m. Staff F, CNA stated she was on the south hall at the time and in with another resident providing cares. Staff F did not hear the alarm sound and did not turn off the alarm. g. During an interview on 8/11/20 at 2:23 p.m., Staff G, CNA stated she was working on the north hall, she did not hear the alarm sound nor did she shut off the door alarm. h. During an interview on 8/12/20 at 1:11 p.m., Staff H, CNA stated she was on the west hall, she did not hear the alarm nor did she shut the alarm off. During an interview with the Administrator on 8/12/20 at 10:05 a.m., the Administrator stated she believes the elopement was due to the fire doors on the south wing being closed due to Covid 19 containment attempt, the 2 aides working on the hall were in resident rooms doing cares with the room door and curtains closed. The resident apparently walked out of the door without staff on the south wing hearing the door alarm sound. During the investigation of the event they discovered the door alarms cannot be heard if staff are in resident rooms with door closed, the alarm sounds loudly in the center of the building and under normal circumstances the fire door would be open and staff could hear the alarms. The Administrator stated when she discovered the alarms could not be heard under those circumstances she contacted the alarm company and has a scheduled appointment to evaluate and make make suggestions. Review of the Door Alarm Response policy dated 11/2/18 directed staff to promptly respond to the door alarm/alerts. The policy directed staff to check the system for location of door alarming and immediately respond to the door that is alarming. Staff are to walk to the door, walk outside, scan the facilty grounds to identify the source of the alarm.

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

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.