STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165251	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RAVENWOOD SPECIALTY CARE	**2651 ST FRANCIS DRIVE WATERLOO, IA 50702**

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

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F 0689 **Level of harm -** 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 observation, record review and staff interview, the facility failed to provide adequate supervision to prevent elopement for 1 of 3 residents reviewed for risk of elopement (Resident #3). Resident #3 eloped from the facility without the staff's knowledge. The facility reported a census of 123. Findings include: Resident #3's Minimum Data Set (MDS) dated [DATE] documented [DIAGNOSES REDACTED]. The MDS documented a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. The MDS documented the resident was frequently incontinent of both bowel and bladder. Review of the Care Plan identified the resident as at risk for falls, potential for skin breakdown due to urinary incontinence and at risk for elopement. The focus area for elopement risk included interventions of a wander guard placed on August 23, 2018 and 15 minute checks initiated on June 10, 2019. The care plan had an intervention dated August 23, 2018 to distract from wandering by offering pleasant diversions, structured activities, food, conversation, TV shows and books the resident prefers. Care plan interventions with initiation dates of 7/6/20 and revision date of 7/7/20 identified the resident was in quarantine (as a COVID-19 precautionary measure) and had alarms placed on the room door and bathroom door to alert staff if he began to wander due to his quarantine and to help with his elopement risk. The window cranks had been removed from the window in his room as he was known to mess with the window screens-initiation date 7/6/20. The care plan has a focus area identified of: I am feeling restless and anxious. My doctor has ordered that I am able to have alcohol twice a day for a calming aid with an initiation date of 7/30/2018. A virtual visit completed on 7/6/20 at 8:30 a.m. by the ARNP (Advanced Registered Nurse Practitioner) for the facility documented an order for [REDACTED]. Review of the resident's Treatment Administration Record for July documented the wander guard had been checked every shift, with the last check occurring during the evening shift on July 6, 2020. Review of the Fifteen Minute Checklist for the past 30 days documented the resident as being visualized every 15 minutes, day and night, except for the time period when the resident was out of the facility (OOF) for an appointment on July 6, 2020. Review of the progress notes documented the following: Progress Note dated January 8, 2020 at 4:07 a.m. documented the resident was in bed at that time and 15 minute checks continued. Progress note dated January 10, 2020 at 1:22 p.m. documented Resident #3 had been actively seeking exits for 8 hours and had removed the window screen in the day room and opened the windows. The nurse documented she put in a maintenance request to remove the cranks from the windows. Progress Note dated January 21, 2020 at 12:51 p.m. stated family and friends visit often and take him out into the community often. January 24, 2020 at 12:13 p.m., the MDS coordinator documented Resident #3 had returned from a leave of absence to Florida. Progress Note dated February 6, 2020 at 9:17 p.m. stated 15 minute checks continued and no exit seeking behavior. Progress note dated March 2, 2020 at 4:37 a.m. documented Resident #3 was resting in bed with his eyes closed, no attempts to get up. Progress note dated March 18, 2020 at 9:35 p.m., nurse documented Resident #3 has attempted to escape all evening. He tried opening a window but was caught by aide and had been climbing on the toilet as well. Progress noted dated(NAME)23, 2020 at 12:30 a.m. documented Resident #3 was given prn (as needed) Captain(NAME)(alcohol) at 10:42 p.m. due to restlessness, continue to monitor for safety and exit seeking. Progress Note dated March 24, 2020 at 7:19 a.m. stated no anxiety noted, continued on 15 minute checks. Progress Note dated April 2, 2020 at 1:32 a.m. stated wander guard in place and working, no anxiety. Progress note dated April 9, 2020 at 11:44 a.m. stated Resident #3 disassembled a wheelchair back up brake and was redirected multiple times during the shift. Progress note dated April 15, 2020 at 10:04 a.m. stated the resident required increased supervision, was found in room [ROOM NUMBER] attempting to go out the windows, redirection given. Progress note dated April 17, 2020 at 1:48 p.m. documented the resident had to be redirected 20 times from going into the day room. The resident had taken the screen off the window and maintenance had completed a repair. Staff was aware of his attempts to leave the facility and 15 minute checks were ongoing. Progress Note dated April 20, 2020 at 3:15 a.m. documented the resident was resting in bed with his eyes closed at that time. He had an alcoholic drink at 10:30 p.m. due to restlessness. Progress note dated April 29, 2020 at 1:06 p.m. stated Resident #3 was anxious and attempted to get out of the window in room [ROOM NUMBER]. The resident had the screen off and and was attempting to climb on the heater to get outside. The crank was removed from that window for safety. Progress Note dated April 30, 2020 at 4:30 a.m. documented wander guard was checked and working. Progress Note dated May 1, 2020 at 1:08 a.m. documented the wander guard was checked and working. Progress notes dated May 6, 2020 at 2:17 a.m. stated the wander guard was in place, checked and working. Progress Note dated May 12, 2020 at 1:21 p.m. documented the resident was not following instruction, not wearing face mask, and running out of his room. He was observed taking the screen off of the window in room [ROOM NUMBER]. The screen was replaced and the door to the room was closed. Progress note dated May 19, 2020 at 9:06 p.m. documented Resident #3 was seen walking out of the D-wing back door, heading outside after supper. The alarm sounded. Staff saw the resident and remained in the staff member's visual field the entire time until he was back in the facility. The resident was taken to his room and given some rum. 15 minutes safety checks continued. Resident #3 was in his bed in his room at the time the note was written. Progress note dated May 26, 2020 at 6:01 a.m. stated the resident was out of his room from 5:00 a.m. to 6:00 a.m. He was redirected and assisted back to his room. Interventions of being taken to the restroom, water, and turning on the TV were ineffective. Oncoming charge nurse advised of restlessness. Progress Note dated June 4, 2020 at 8:48 a.m. documented the resident was attempting to climb out the window in room [ROOM NUMBER]. The resident in that room had a hold of Resident #3's pant leg to keep him in the room and screamed for help. Resident #3 was given alcohol and soda. He calmed down and was able to fall asleep. Progress Note dated June 5, 2020 at 4:19 a.m. documented the resident was resting in bed with his eyes closed. His wander guard was checked and working. He had no attempts to leave the facility by door or window. Progress Note dated June 12, 2020 at 3:03 p.m. documented the resident was wandering, exit seeking and leaving his room. He was redirected easily and given a snack. Progress Note dated June 12, 2020 at 3:45 p.m. documented a CMA (certified medication aide) discovered the resident had removed the screen from the room across the hall and was attempting to crawl out the window. He was still in the building and redirected to his room. There was a movie playing and he finished his alcohol that had been given previously. Progress Note dated June 18, 2020 at 1:07 a.m. documented the resident was still up pacing in his room and then out in the hallway. He was assisted back to his room and given a drink which was effective. The resident was resting in bed at the time this note was written. Progress Note dated June 18, 2020 at 3:47 p.m. documented a conversation between facility staff and Resident #3's wife. The wife stated she was going to take Resident out of the facility for a graduation and keep him home overnight. Facility staff and Advanced Registered Nurse Practitioner (ARNP) explained that Resident #3 would not understand social distancing, keeping a mask on or self-isolation and attending the ceremony would put the facility population at risk. Wife stated she was taking him anyway. Facility staff advised that would be against medical advice. Progress Note dated June 18, 2020 at 4:11 p.m. documented facility staff had a conversation with Resident #3's wife stating if she were to take the resident out for

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

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) graduation it would be an emergency discharge. The wife verbalized understanding as stated she would call the governor and state senator's office. Facility reminded her they were following Iowa Department of Public Health (IDPH), Center for Disease Control (CDC) and Department of Inspections and Appeals (DIA) guidelines. Facility Medical director and ARNP were aware of situation and supportive. Progress Note dated June 18, 2020 at 4:28 p.m. documented conversation with the wife on speaker phone with Resident #3 explaining there is [MEDICAL CONDITION] spreading through the community and explained to the resident why he was unable to leave the facility to go to the graduation. He was offered to have a computer set up to watch it virtually and he said that sounded good. Wife stated she would be picking him up for the graduation and was bringing the police with her. The wife stated she was looking for another place for Resident #3 to live. Facility offered assistance with alternative placement. The resident's wife stated she would be contacting everyone she can about this. After the call, the resident was assisted to his room to watch a movie. Progress Note dated June 19, 2020 at 1:57 p.m. stated a chart review was completed for hospice eligibility per the wife's request. The resident was not appropriate for hospice care at this time. Progress Note dated June 19, 2020 at 2:29 p.m. documented wife notified of hospice ineligibility. Wife states she had not made up her mind about taking him out to graduation. She was reminded of emergency discharge. Progress Note dated June 20, 2020 stated the resident's wife had decided not to take Resident #3 out of facility and declined offered virtual viewing. Progress Note dated June 25, 2020 at 4:13 p.m. stated the wife set up an appointment with [MEDICAL CONDITION] treatment center in Cedar Rapids for July 6, 2020 and she was going to take him. Facility staff called the doctor's office asking got a telehealth session. The doctor's office deferred a decision to the wife but did state they were able to do telehealth sessions. Progress Note dated June 26, 2020 at 2:07 p.m. documented wife was contacted about telehealth. Facility staff explained labs could be drawn at facility and sent to Mercy One. The resident's wife stated she would look into it and let the facility know. Progress Note dated June 28, 2020 at 4:37 a.m. documented the resident had not displayed any anxiety. His wander guard checked and working. Progress Note dated June 30, 2020 at 2:08 p.m. documented the doctor's office called the facility and stated the visit on July 6, 2020 could be telehealth. The facility attempted to call the resident's wife. Progress note dated July 4, 2020 at 3:34 a.m. documented the resident's wander guard was checked and working. Resident #3 did not have any anxiety or attempts to leave facility. Progress note dated July 6, 2020 at 10:54 a.m. documented the resident's wife was notified of the need for him to go to a different room upon return to the facility from the doctor's appointment (for COVID-19 precautionary isolation). Progress note dated July 6, 2020 at 1:14 p.m. documented the doctor's office called the facility and stated the visit needed to be done in person and was medically necessary. The facility set up transportation and a Certified Nurse Aide (CNA) escort for the resident. Progress Note dated July 6, 2020 at 1:16 p.m. documented the resident's wife and daughters were waiting outside the facility for the resident to get into the arranged transportation vehicle. The resident's wife refused to social distance and hugged Resident #3. The resident's wife assisted him into the transportation van and then followed the van to the doctor's office in her car. Progress note dated July 6, 2020 at 10:45 p.m. documented the CNA yelled out from resident's room that he was not in the room. The window was open and the screen was on the floor. The nurse jumped out the window and searched immediate area outside while staff searched inside. The nurse got in his vehicle and continued the search. Progress note dated July 7, 2020 at 6:24 a.m. IMPACT team (facility's medical team, ARNP's office) was notified of resident's situation. Progress note dated July 8, 2020 at 10:20 a.m. stated that the resident's wife was notified that the resident left the facility through a window on July 6, 2020 at 11:20 p.m. Review of the surveillance video from the front door of the facility, on July 6 at 6:00 p.m., showed the resident entering the facility with the assistance of Staff C. The video revealed a staff person at the door when the resident entered the building keying in the code to quiet the wander guard alarm. Review of the 15 minute check list documented Resident #3 was out of the facility from 1 p.m. on 7/6/20 until visualized again at 6:00 p.m. on 7/6/20 when he returned from the doctor's appointment. Review of the facility's missing resident procedure and Code Yellow (missing resident) policy outlined the steps to be taken in the event of a missing resident. The facility followed the policy, searching the facility and grounds as outlined. The facility followed the procedure, notified all appropriate staff, law enforcement, emergency services and local hospitals. All agencies were in frequent contact with the facility over the days the resident was missing. Statements were collected by the facility from staff on duty the night of July 6. The statements documented a code yellow was activated and the areas outside the facility and the city had been searched immediately. Multiple additional staff were called to assist in the search as well. July 7, 2020 the facility assigned staff to search specific areas of the city. The resident's wife was notified at 11:15 p.m. and the local police department was notified at 11:19 p.m. on July 6, 2020. The facility also collected a statement from an alert and oriented resident 2 doors down from Resident #3. In a statement collected by the facility, Staff E stated she had checked on Resident #3 at 10:15 p.m. and he was sleeping. She stated she checked on the resident again at 10:31 p.m. and he was still asleep. In a statement collected by the facility on July 7, 2020, Staff F stated she was checking on the resident on his 15 minute check around 10:45 p.m. or so. She noticed the screen was off the window and the resident was not in the room. She alerted the nurse and ran out the back door and began searching for the resident. During an interview with the Administrator, Assistant Administrator and Director of Nursing (DON), the Assistant Administrator outlined the timeline of events for the last few weeks. All events were documented in the progress notes. During an interview on July 8, 2020 at 6:15 p.m., Staff C confirmed she assisted the resident to the transportation van on July 6, 2020 a little before 1:00 p.m. She stated the taxi driver was acting weird and was really trying to get Resident #3 to like him. When arriving at the doctor's office, Staff C had to wait in the first floor waiting room as the receptionist would not allow too many people up to the second floor office. Resident #3, his wife, 3 daughters and a male with a guitar all went upstairs to the second floor office. Staff C confirmed she was able to see the wife's car the whole time she was in the waiting room and it did not move. At 3:30 p.m., Staff C texted Resident #3's daughter to ask how much longer they would be so Staff C, CNA, could let the transportation service know. The daughter responded it would be another hour or so. Staff C stated she went outside to tell the driver it would be a while longer. The driver stated to his dispatch that the CNA is right here and listening, she told me it will be a while longer. Resident #3's daughter sent a text to Staff C at 4:34 p.m. stating they were just finishing up. Resident #3 and Staff C were in the transportation van at 4:58 p.m. to leave the office. Staff C stated Resident #3 seemed his usual self. Resident #3 and Staff C were both wearing masks, but she stated she did not smell alcohol on his breath. Staff C assisted Resident #3 to his new (isolation) room and let staff on that hall know he had been incontinent and then went to her assigned hall to work. During an interview on July 8, 2020 at 6:36 p.m., Staff D stated he visualized Resident #3 in his room at 10:00 p.m. on July 6, 2020. He stated the resident was wearing gray sweatpants and a plaid shirt. Staff D stated he visualized the resident again at 10:15 p.m. At that time Resident #3 was in his bed, under the covers. Staff D stated staff F yelled down the hall at 10:41 p.m. that Resident #3 was not in his room and the window was open. Staff D ran down to the resident's room and jumped out the window to search the immediate area outside and went around the facility to the parking lot. Staff D called into the facility to let the other nurse on duty he didn't see the resident and was going to continue the search in his car. Staff D called the resident's wife from his car about 11:15 p.m. He said the resident's wife was very calm and not upset. Staff D then drove around Target, Home Depot, Yes Way (gas station) and Walgreens. Staff D returned to the facility between 1:30-2:00 a.m. Staff D stated there was nothing bent or broken on the window. During an interview on July 16, 2020 at 12:58 p.m., Staff D stated the resident wandered out of his room just before 8:00 p.m. on July 6, 2020. He stated the resident needed his brief changed. The aide saw him within seconds and took him to the shower room to be changed. Resident #3 was directed to his room on C hall. Staff D stated there was not a crank in the room or on the window the resident went out. During an interview on July 16, 2020 at 12:55 p.m., Staff E stated there was not a crank on the window in the room the resident went out. She stated her shift on July 6 started at 10:00 p.m. and she did not see the resident out of his room. During an interview on July 15, 2020 Staff G stated he removed all the window cranks from all windows on the C wing (where Resident #3 would be temporarily isolated after his doctor's appointment) and on the A wing where the resident's regular room was. He stated all the cranks were kept together while being removed and immediately taken to the maintenance shed. Staff G stated there is absolutely no chance he could have missed the resident's room or placed the crank in a drawer or on a shelf in the resident's room intending to return for it later. Review of hospital emergency room records revealed Resident #3 was taken to the emergency roiagnom on [DATE], no time documented. Resident #3 was seen by the emergency room physician at 11:25 a.m. His temperature was 35.8 degrees Celsius (96.44 degrees Fahrenheit) per EMS. No additional temperatures were documented. Emergency Documentation documented the resident was found in about 2 feet of water, submerged up to his chest. Integumentary review stated no rashes or [MEDICAL CONDITION]. Extremity physical exam documented [DIAGNOSES REDACTED] (redness) on his forearm and hands bilaterally as well as macerated feet appeared to be soaking in water. The resident was alert and oriented to person, place and time with no sensory deficit

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) and no motor deficit. The resident was admitted to the Intensive Care Unit (ICU) [MEDICAL CONDITION], hypothermia, elevated troponin (lab test measuring skeletal or heart muscle damage) and altered mental status. Observation of Resident #3's C-wing room on July 7, 2020, where he had been moved to the night he went missing showed the room window to be open 9 inches. There was no crank on the window. There were hand prints and smudges on both the inside and the outside of the window. During a room walk through on July 8, 2020, two surveyors, the facility administrator and the facility maintenance supervisor all attempted to open the window by hand without a crank with no success. During an interview with the Administrator on July 8, 2020 regarding how the resident could have gotten out of the window in 11 minutes (from 10:30 p.m. to 10:41 p.m.) and not be able to be located, the Administrator stated she was unsure as to how the resident was able to elope.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview and observation, the facility failed to provide proper incontinence care for 1 of 3 (Resident #2) residents observed. The facility reported a census of 123. Findings include: Review of the Minimum Data Set (MDS) dated June, 2, 2020 for Resident #2 documented a Brief Interview for Mental Status (BIMS) score of 0 which indicated severe cognitive impairment. The MDS documented [DIAGNOSES REDACTED]. The MDS documented the resident was frequently incontinent of urine and occasionally incontinent of bowel. Review of a Care Plan documented a focus area of alteration in elimination related to incontinence of bowel and bladder. Review of the facility's Incontinence Care/Peri Care policy dated January 2015, documented all soiled areas to be cleansed front to back. During an observation on July 14, 2020 at 12:30 pm, Staff A and Staff B approached Resident 2's room to perform incontinence care. Staff A and Staff B washed their hands and applied gloves. The resident's pants were pulled down to the ankles and the wet brief was unfastened and pushed down between the resident's legs. The resident had been incontinent of urine. Staff A cleansed the resident's hips, abdomen, legs and frontal perineal area using a front to back motion. Resident #2 was turned on to the right side. Staff A cleansed between the resident's buttocks in a back to front motion then, using a clean wipe, cleansed between the buttocks in a front to back motion. Staff A cleansed both buttocks in a front to back motion then wiped between the resident's buttocks in a back to front motion. Staff A removed her gloves, performed hand hygiene and applied clean gloves while Staff B applied barrier cream to the resident's bilateral buttocks. Staff B removed her gloves, performed hand hygiene and applied clean gloves. Staff A placed a clean brief under the resident and assisted the resident to roll to the left side. Staff B pulled the brief fully under the resident and assisted her to roll to her back. Staff B pulled the brief up between the resident's legs and fastened it. Staff A removed the resident's pants and derm savers (protective skin covers). Pants were placed in a plastic bag. Staff A and Staff B removed gloves and performed hand hygiene. The resident's bed was lowered, body pillow placed under the fitted sheet on her left side, covered up with blankets and call light was in reach. Staff A and Staff B performed hand hygiene. Staff B took the plastic bags with the trash and clothes and both exited the room. During an interview on July 15, 2020 at 9:51 A.M., the Director of Nursing (DON) stated she would expect incontinence care to be performed in a front to back manner, not wiping between the buttocks from back to front. She stated she did see Staff A wiping from back to front.