STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165606	A. BUILDING _____ B. WING _____	**07/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PERRY LUTHERAN HOME	**2323 EAST WILLIS AVENUE PERRY, IA 50220**

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to review and revise care plans for 2 out of 6 residents reviewed (Resident #1 and Resident #4). The facility reported a census of 65 residents. Findings include: 1. A Minimum Data Set (MDS) with a completion date of 12/9/19, for Resident #1, listed [DIAGNOSES REDACTED]. The Brief Interview for Mental Status (BIMS), documented an 8 out of 15 indicating moderate cognitive impairment. The MDS documented the resident wandered daily. The resident was independent with ambulation, however, supervision when off the unit. Care Plan: A Care Plan problem area with onset date of 11/27/19, identified the resident at risk for wandering throughout the neighborhood and at times exit seeking behavior related to [DIAGNOSES REDACTED]. The care plan failed to identify that the resident had a wander guard alarm/bracelet in place. The care plan was updated to include the following interventions: medication adjustment (12/17/19), staff to monitor whereabouts and not allow resident to leave unit (12/17/19, and 15 minute checks (12/18/19). Care plan problem area with onset date of 12/7/19, identified the resident as a smoker and able to smoke in a designated area with constant supervision. Interventions included: staff must remain outside in the designated smoking area and maintain constant supervision while the resident smokes. This problem was discontinued on 3/17/20. The care plan failed to identify that the resident required 2 staff present when going outside to smoke. The care plan was updated to include no smoking (12/17/19). Interview on 7/1/20 at 11:58 AM, the MDS Coordinator stated Resident #1's base line care plan and comprehensive care plan should state the resident required assist of 2 staff to go outside to smoke 2. A Minimum Data Set (MDS) with a completion date of 6/24/20 for Resident #4, listed [DIAGNOSES REDACTED]. A Brief Interview for Mental Status (BIMS) test identified a score of 00 (severe cognitive impairment). The MDS identified the resident required extensive assistance of two staff for bed mobility and transfers, and depended on staff for locomotion. Ambulation did not occur during the seven day assessment period. Care Plan: A Care plan problem area with an onset date of 4/2/18, identified the resident with a self-care deficit related to [DIAGNOSES REDACTED]. Intervention included transfer with Hoyer lift and assist of 2. Observations: 6/29/20 at 4:15 PM, Staff N CNA (certified nurse aide) and Staff P CNA transferred the resident from the Broda Chair to the toilet and back to the Broda chair with the use of an EZ-Stand Lift. 6/30/20 at 8:05 AM, Staff I CNA and Staff J CNA transferred the resident from his bed to the Broda Chair with the use of an EZ-Stand lift. Physician orders: 1/12/20, may use EZ-Stand for transfers 1/13/20, Physical therapy/Occupational therapy to evaluate and treat for transfers Document titled CNA Resident Information Sheet updated 6/29/20, identified the resident utilized the EZ-Stand lift with assist of 2 for transfers. Document titled Rehab Communication dated 1/22/20, instructed the staff to transfer with EZ-Stand and assist of 2. On 7/1/20 at 11:58 AM, the MDS Coordinator, stated she believed the resident required Hoyer lift for transfers per the care plan. The MDS Coordinator stated in April 2020, the facility completed a transfer audit to ensure care plans, pocket care plans, and what staff did all matched. The MDS Coordinator stated the CNA's would change practices on their own without letting anyone know. On 7/1/20 at 12:37 PM, the DON stated the resident is an EZ-stand transfer and care plan should state that and not Hoyer lift.
F 0689 **Level of harm -** Immediate jeopardy **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, policy review, and staff interview the facility failed to adequately supervise residents while outside the facility smoking for 1 of 2 residents reviewed. Staff did not provide adequate supervision to a resident who walked away from the facility while staff failed to maintain constant supervision of the resident as the care plan directed. This resulted in past noncompliance immediate jeopardy for the facility. The facility reported a census of 65 residents. Findings include: Resident #1's Minimum Data Set (MDS) with a completion date of 12/9/19, listed [DIAGNOSES REDACTED]. A Brief Interview for Mental Status (BIMS) test identified the resident with a score 8 (moderate cognitive impairment). The MDS documented the resident wandered daily. The resident was independent with ambulation, however, supervision when off the unit. Care Plan: A Care Plan problem area with onset date of 11/27/19, identified the resident at risk for wandering throughout the neighborhood and at times exit seeking behavior related to [DIAGNOSES REDACTED]. The care plan failed to identify that the resident had a wander guard alarm/bracelet in place. The care plan was updated to include the following interventions: medication adjustment (12/17/19), staff to monitor whereabouts and not allow resident to leave unit (12/17/19), and 15 minute checks (12/18/19). Care plan problem area with onset date of 12/7/19, identified the resident as a smoker and able to smoke in a designated area with constant supervision. Interventions included: staff must remain outside in the designated smoking area and maintain constant supervision while the resident smokes. This problem was discontinued on 3/17/20. The care plan failed to identify the resident required 2 staff present when out to smoke. Care Plan problem area with onset date of 11/27/19, identified the resident with potential for alteration in behavior related to history and [DIAGNOSES REDACTED]. The care plan was updated to include no smoking (12/17/19). An Elopement/Wandering Risk Assessment with a completion date of 12/8/19, identified the resident at high risk for wandering due to mobility, history of wandering, [DIAGNOSES REDACTED]. A Safe Smoking Risk assessment with a completion date of 12/7/19, identified that the resident required supervision while smoking. An incident report dated 12/17/19 at 2:57 PM, revealed Resident #1 left the facility grounds at 12:50 PM. Narrative of incident and description of injuries: resident left facility grounds at 12:50 PM and no injuries noted upon skin assessment. Immediate actions taken: called 911, searched community, resident returned to the facility safely. The incident report failed to document the time the resident returned to the facility or vital signs taken upon the return. A Perry Police Report, Call for service record with a call number of 78, at 1:11 PM on 12/17/19, revealed Perry Lutheran Home reported a missing resident. Dispatcher notified the sergeant and at the same time received call from the maintenance man at the Perry Super 8 Motel, reporting female matching description. Perry Police relayed the information to Perry Lutheran Home and the facility sent someone to get the resident. Review of Elopement Risk information book, located in the financial office: Front pocket contained document titled placement of wander guard dated 1/1/18 and Missing resident code pink document undated 1st tab contained the residents from the 1st floor of the facility that were elopement risk, with their pictures attached to their face sheets 2nd tab contained the residents from St. Johns secured unit that were elopement risk, with their pictures attached to their face sheets 3rd tab contained the residents from St. James secured unit that were elopement risk, with their pictures attached to their face sheets The Elopement information book was not up to date with the current residents who the facility identified as elopement risk. Review of Report book on 6/30/20, for each secured unit contained: Document titled missing resident procedure undated Daily QA condition change

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.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) audit dated 6/29/30, with residents changes and information pertinent for the staff Report sheets Document titled Assessment thought process guidelines, undated Documentation reminder Review of an undated document titled Missing Resident Procedure: The missing resident episode must be documented in the resident's chart and incident report completed Resolution of the episode shall be documented in the resident's chart and incident report Upon return to the facility, head to toe assessment shall be completed and documented in the resident's chart Review of an undated document titled Assessment Thought Process Guidelines, directed staff of areas to assess during a head to toe assessment; included vital signs. Review of Communication book on 6/30/20, for St. John's secure unit: Document titled St. John's staff dated 4/9/20 - informed staff about the communication book: read & initial daily, located on medication cart or nurses desk, any staff can add pertinent information about residents, and is available for all staff to provide the most up to date care on all St. John residents Pocket care plan sheets dated 6/29/30 Environmental Aide schedule No signature sheets included Review of Communication book on 6/30/20, for St. James secure unit: Document titled St. James staff dated 3/3/20 - informed staff about the communication book: read & initial daily, located on medication cart or nurses desk, any staff can add pertinent information about residents, and is available for all staff to provide the most up to date care on all St. John residents Pocket care plan sheets dated 6/29/30 Environmental Aide schedule Document titled 4/7/20 St. James staff - explained the pocket care plans and that they would be updated on Mondays and Thursday/Friday Signature sheet in back 5 staff signed and dated 3/3/20 and 1 staff signed an dated on 3/5/20 Review of progress notes: 12/7/19 at 1:02 PM, telephone order per the resident's primary care physician, ok to leave nicotine patch on and allow the resident to smoke outside with staff two times a day. 12/7/19 at 1:34 PM, documented finally got an order for [REDACTED]. Head to toe assessment completed and no abnormalities. The entry did not contain assessment of vital signs. Resident #1's Electronic Health Record (EHR) for 12/17/19, did not contain vital signs documented in the Vital Signs section. Policy: Document titled Missing Resident dated September 2017 with a revision date of April 2019, stated upon return of the missing resident nursing would: Examine resident for injuries Contact the attending physician and report findings and condition of the resident Contact the residents legal representative Complete an incident report Make appropriate entries in the residents medical record During Entrance Conference on 6/29/20 at 1:15 PM with the DON, he stated he did not know if the facility had a policy regarding residents smoking, however, would look into it. The DON stated the facility was a non-smoking facility and made an exception for this resident due to her increased behaviors. The DON stated the facility tried to allow the resident to smoke instead of medication use for her behaviors. During initial interview with the Administrator on 6/29/20 at 3:03 PM, she stated the facility was a Smoke Free Facility since 2013 and was unaware if there was a smoking policy. When questioned on 6/30/20 at 9:03 AM and 10:44 AM, the DON again stated did not know if the facility had a smoking policy. On 6/30/20 at 11:16 AM the DON provided the surveyor a copy of the Accidents and Supervision Smoking Policy undated. The DON stated on 6/30/20 at 3:58 PM, that he located the policy on the computer and that the facility policy book did not contain this policy. The DON stated he would not expect staff to comply with the policy due the policy not available for staff in the policy book and facility a smoke free facility. On 6/29/20 at 2:25 PM, Staff A CMA (certified medication aide), stated she took Resident #1 out to smoke on 12/17/19. Staff A stated she was scheduled on 12/17/19, as Restorative Aide however, assisted residents on secured unit with lunch when Resident #1 continuously asked to go outside for a cigarette. Staff A stated staff usually took the resident out to smoke after lunch, however, the facility did not have scheduled smoke times. Staff A stated she knew the resident had exit seeking behavior and always wanted to go home. Staff A stated she did not previously ever take Resident #1 out to smoke. On 12/17/219 Staff A took the resident downstairs and out the East door to smoke. Staff A proceeded to demonstrate how she handed Resident #1 her lighter and cigarette and reset alarms. Staff A stated she stopped at the cigarette stack (fire proof container where cigarette butts are placed after smoking) with her back to the resident. She stopped at the cigarette smoke container due to cigarette butts on the top and she needed to push them down into the container. Staff A stated she talked to Resident #1 while she did this, however, the resident stopped talking and Staff A turned around to find the resident gone. Staff A believed the time as less than 30 seconds. Staff A stated she asked a construction crew working on the front side of the building if they observed the resident and they said no. However, Staff A stated when other staff asked the construction crew, they reported the resident got into a white car at the corner of Willis Street. Staff A stated she looked in the parking lot briefly and around the building prior to going inside service door to notify administration. On 6/29/20 at 3:03 PM, the Administrator stated she thought Staff A was tried helping by taking Resident #1 outside to smoke. The Administrator stated staff on the secure unit told Staff A she needed 2 staff present when taking Resident #1 outside to smoke. The Administrator played the facilities video footage from 12/17/19 at 12:48 PM, observation of the footage showed Resident #1 come from the east entrance of the facility onto the ramp, stopped approximately half way down the ramp, and then proceeded to the end of the ramp and turned to her left, where she stopped again. The resident proceeded down the sidewalk, heading north towards Willis Street when she is no longer visible and a white car is seen driving east on Willis. The elapsed time from when you first see the resident until you no longer can visualize her, and the white car is seen on Willis is 8 seconds. From the video footage, Staff A, looked to the left of the ramp, towards Willis and then the right, into the facility parking lot. The Administrator stated Staff A came into the facility to inform them and immediately conducted an internal and 2 block external sweep. The Administrator stated she returned inside to view with video footage and call the police. The Administrator stated within a short time the police called back to the facility to inform them of a pleasantly confused lady at the Super 8 Motel matching Resident #1's description. The Administrator stated the facility staff knew the resident required 2 staff to go outside and smoke from the unit communication book, stated she would provide the documentation. The Administrator stated she did not know any behaviors the day Resident #1 eloped. The Administrator stated she did not know if staff completed a vital sign assessment upon Resident #1's return to the facility. The Administrator stated they learned their lesson and they are a Smoke Free Facility, and no exceptions. On 6/29/20 at 4:28 PM, Staff A stated she did not know of a smoking policy. Staff A stated she knew the residents needed to wear a smoke apron and thought one staff could take the residents out to smoke. Staff A stated if there was a change in how many staff needed to take Resident #1 out to smoke a cigarette, the charge nurse who gave her the cigarette should have informed her of that. On 6/30/20 at 7:59 AM, Staff J CNA stated she never took Resident #1 outside to smoke. Staff J stated Resident #2, located downstairs, was previously upstairs in a secure unit and the facility allowed him to go outside to smoke with 1 staff, however, no longer allowed him to smoke. Staff J stated she would check the pocket care plans for instructions when taking residents out and number of staff required. On 6/30/20 at 7:59 AM, Staff I CNA stated she never took Resident #1 outside to smoke. Staff I stated 2 staff would usually take the resident out and did not know if one staff ever took the resident out. Staff I stated she never took Resident #2, located downstairs, out to smoke either. Staff I stated she worked at the facility for one year and since that time Resident #2 lived downstairs. Staff I stated she would check the pocket care plans for instructions when taking residents out and number of staff required. On 6/30/20 at 9:03 AM, the DON stated Resident #1 could smoke in attempt to decrease her behaviors. The DON stated they initially made the decision on a weekend (12/7/19) due to Resident #1 throwing a vase at a window, however, they determined 2 staff needed to accompany the resident when she went out. The DON stated immediately following the incident, Resident #1 could not go out of the facility to smoke. The DON identified Resident #1 as new to the facility and did not have a history of elopement at previous facility due to her being allowed to smoke. The DON stated when Resident #1 admitted to Perry Lutheran they initially did not allow the resident to smoke and she developed behaviors. The DON stated staff took Resident #1 outside the facility on 12/17/19, right after lunch with one staff present. The DON stated Resident #1 went out previously to smoke, however, 2 staff always accompanied the resident. The DON stated the facility suspended Staff A for 7 days due taking Resident #1 out to smoke alone and could no longer take residents outside alone. The DON stated Staff A can no longer work as a Restorative Aide and float to units or first floor. Staff A is required to be scheduled as CNA or CMA on a specific unit/floor. On 6/30/20 at 9:56 AM, Staff B Certified Nurse's Aide (CNA), confirmed she worked on the secured unit on 12/17/19, the day Resident #1 eloped. Staff B stated Resident #1 usually asked around 10:30 AM, to go outside to smoke, however, she did not recall if staff took the resident outside at that time or not. Staff B stated that either right before or right after lunch Resident #1 asked again and staff informed her she needed to wait until later. Staff B stated Resident #1 cried and appeared agitated due to wanting to go outside to smoke. Staff B revealed 2 CNA's worked on the secured unit and one nurse so they offered Resident #1 coffee and attempted to make her comfortable. Staff B did not recall why Staff A came to the unit. Staff B stated Staff A offered to take Resident #1 outside to smoke, however, Staff B informed Staff A she did not think it was a good idea. Staff B stated she felt Resident #1 was pretty smart and felt concern she would attempt to leave due to the resident wanting to go home. Staff B stated she did not tell Staff A to take 2 staff when she took Resident #1 out to smoke due to not present when Staff A and Resident #1 left the

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) secure unit. Staff B stated she yelled down the hall at Staff C CNA, to have her tell Staff B that the resident required 2 staff to go with her to smoke. Staff B stated she took Resident #1 outside the facility to smoke in the past and always with another CNA. Staff B stated when she took Resident #1 off the secure unit to smoke, the resident did not attempt to leave the smoking area. Staff B stated Resident #1's behavior on that day (12/17/19) did not appear any different than her regular behaviors. Staff B stated she knew the resident required 2 staff to take her outside to smoke due to a note in the communication book. Staff B stated she did not recall if the note was before or after the incident. Staff B stated if she identified a missing resident she would alert the nurse on duty and follow instructions in the book on the unit. On 6/30/19 at 10:42 AM, Staff C CNA, confirmed she worked on the secured unit on 12/17/19, the day Resident #1 eloped. Staff C stated Resident #1 appeared anxious that morning and wanted to go outside to smoke. Staff C identified staff as busy and unable to take the resident out to smoke. She informed the resident that she would have to wait until after lunch. Staff C stated the resident got upset and wanted to go right now. Staff C stated Staff A came to the secured unit at lunch for restorative and offered to take Resident #1 outside to smoke. Staff C stated that she and Staff B informed Staff A that 2 staff needed to go with the resident to smoke. Staff C stated she received the information regarding the resident needing 2 staff during report. Staff C stated she never took Resident #1 outside of the facility to smoke. Staff C stated if she discovered a missing resident she would notify the DON & Administrator and follow the elopement book instructions located in the Financial office. On 6/30/20 at 10:44 AM, the DON stated he did not have documentation from the communication book that identified when Resident #1 could go out of the facility to smoke with 2 staff present. The DON stated the staff must have wrote a note in regards to this but he did not have anything. The DON stated Staff D Licensed Practical Nurse (LPN) was transitioning into her current role as Assistant Director of Nursing (ADON) and making changes in the communication books on the units for the staff. The DON stated Staff D is currently putting a Quality Assurance (QA) report in the communication book every morning with changes that staff need to be aware of. On 6/30/19 at 10:56 AM, Staff D LPN stated the day Resident #1 eloped (12/17/19) she worked in the office of the MDS Coordinator. Staff A came in to ask if she could take Resident #1 outside for a cigarette. Staff D stated herself and the MDS Coordinator informed Staff A she could take Resident #1 outside for a cigarette, however, she needed another staff to go with as the resident required 2 staff present. Staff D stated she did not know how Staff A obtained Resident #1's cigarette and lighter. Staff D stated a report book contained information that Resident #1 required 2 staff to take her outside of the facility to smoke. Staff D stated she could not locate the report book at this time. Staff D stated the units now have communication books in place so any staff can make notes in it. She places QA sheets in them daily with updates or changes for residents. Staff D stated she verbally tells staff of changes, anything new, or requests staff to make sure to read the communication book. Staff D confirmed she completed the incident report on 12/17/19 when Resident #1 eloped. Staff D stated she took the residents vital signs upon return to the facility, but she can not find them documented in the nurse's notes or on the incident report. Staff D stated she went with the MDS Coordinator to the Super 8 Motel to get Resident #1 following police notification. Staff D stated the motel front desk said they did not know what to do with the resident so they gave her a room upstairs. Staff D stated the MDS Coordinator went upstairs to get the resident and they returned the resident to the facility without incident. Staff D stated she never took Resident #1 out to smoke and did not think the resident would attempt to leave. On 6/30/20 at 11:14 AM, Staff E CMA confirmed she administered medications on the secure unit on 12/17/19, the day Resident #1 eloped from the facility. Staff E stated Resident #1 constantly asked to go outside to smoke but staff could not take her due to lunchtime preparations. Staff E stated Staff A CMA, who worked restorative on 12/17/19, came to the secure unit to assist with lunch. Staff E stated initially Staff A told Resident #1 she needed to wait to go outside to smoke and then agreed to take her out. Staff E stated Staff A received the directive that the resident required 2 staff with her to go out to smoke, however, Staff A spoke with another resident's family member at the time and maybe Staff A did not hear staff telling her that. Staff E stated she did give Staff A Resident #1's cigarette and lighter while she administered medications. She stated she did not observe to ensure Staff A had another staff person with her. Staff E stated if she discovered a missing resident she would notify department heads, complete a head count of the residents, and call police. Staff E identified books in the units with procedure to follow for elopements. Staff E stated she never took Resident #1 outside to smoke. Staff E stated staff informed each other of Resident #1's requirement of 2 staff to take her outside to smoke. She did not recall if this was on the residents pocket care plan. On 6/30/20 at 11:37 AM, the MDS Coordinator identified self as not on the unit on 12/17/19, prior to Resident #1's elopement. The MDS Coordinator stated she did not know Staff A took Resident #1 outside to smoke until she received notification of the elopement. The MDS Coordinator stated she did not remember Staff D and Staff A entering her office to ask about taking Resident #1 outside to smoke. The MDS Coordinator stated Resident #2 could go outside and smoke with only 1 staff present. The MDS Coordinator stated she understood that the DON called the facility on 12/7/19, when Resident #1 could go outside to smoke, and he informed the staff that the resident required 2 staff to take her out. The MDS Coordinator stated at the time of the elopement (12/17/19) the staff did not have pocket care plans. The MDS Coordinator stated she did not know if the QA sheet in the secured unit directed staff to user 2 staff. The MDS Coordinator stated she never took Resident #1 outside to smoke. The MDS Coordinator stated if there a resident is missing, call code pink and staff would go to the Administrators office with the Elopement book and follow the policy. The MDS Coordinator stated she went to the Super 8 to bring Resident #1 back to the facility. The MDS Coordinator stated Resident #1 easily returned to the facility, however, did not want to return to the secure unit and cried. On 6/30/20 at 11:57 AM, Staff F Registered Nurse (RN) confirmed she worked as float nurse on 12/17/19, the day Resident #1 eloped. Staff F identified a new admission arrived that day and when going to the new admit's room, she observed Resident #1 in her room. Staff F stated when she came out of the new admit's room, they informed her Resident #1 eloped. Staff F stated she did not know Resident #1 went out to smoke. Staff F stated she knew the resident required 2 staff to go outside to smoke. She stated she believed the care plan contained the information and staff also discussed it in report. Staff F stated she called the police department and they informed her a lady fitting that description found at the Super 8 Motel. Staff F stated upon Resident #1's return she appeared anxious, sad and confused. Staff F stated Resident #1 had money in her coat pocket when she returned and they placed it in the nurse's cart. Staff F stated Resident #1 asked to smoke upon return, however, did not attempt to leave. Staff F stated with missing residents she would follow the Elopement book; notify the DON & Administrator, call the police and check outside. On 6/30/20 at 2:04 PM, Staff A stated she never took Resident #1 out to smoke prior to the elopement on 12/17/19. Staff A stated she did not know of any type of staff education, information, or procedure review completed prior to staff taking Resident #1 out to smoke on 12/7/19. Staff A stated she did not recall asking Staff D or the MDS Coordinator if she could take Resident #1 out to smoke on 12/17/19 (day of elopement). Staff A stated she did not hear the other staff on the unit tell her she needed to take 2 staff out with Resident #1 when she took her out to smoke and those staff should have stopped Staff A. On 6/30/20 at 2:57 PM, Staff G CMA stated she took Resident #1 outside the facility for a cigarette with 2 staff prior to the 12/17/19 elopement. Staff G stated she came on duty on 12/7/19, when facility administration decided Resident #1 could go outside to smoke with 2 staff. Staff G stated she never had issues with Resident #1 attempting to leave when taken outside to smoke. Staff G stated she worked 2-10 PM on 12/17/19 (day of elopement), and Resident #1 appeared anxious upon return and wanted a cigarette. Staff G stated she took Resident #1 to her room and would talk about her family, boyfriend, and other things to distract her. On 6/30/20 at 3:25 PM, the DON stated the Administrator and Staff H Business Office were responsible for updating the elopement book with current residents' information. The DON stated some of the residents no longer have a wander guard and do not need to be in the elopement book. The DON stated if a resident had a wander guard he would expect their information to be in the elopement book. The list of residents provided to the surveyor had 12 residents listed that had wander guards, however, there were only 8 residents' information in the elopement book. The DON stated they needed to do better with updating the Elopement book. Interview on 7/1/20 at 8:07 AM, the Administrator stated she does not update the Elopement book. She stated she did not know if that was the MDS Coordinator or Staff D kept the elopement book updated. The Administrator stated she did not exactly know the process of how they decided what residents were in the book and stated there was probably a process breakdown. The Administrator stated she did not know why the residents with wander guards were not in the elopement book. The Administrator stated the facility no longer allow residents to smoke. The Administrator stated they reviewed the Elopement policy and completed an encompassing review of Resident #1 regarding what they knew prior to admit and what they didn't know in regards to her smoking and behaviors. The Administrator stated staff present on 12/30/19 for education signed in and the facility called other staff to inform them. She stated she did not know where the complete list of staff was located. The Administrator stated she did not speak with anyone that worked at the Super 8 Motel. On 7/1/20 at 8:51 AM, the Director of Environmental Services (ES) stated she or Staff K emptied the smoke stack

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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 -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) ashtray located at the East entrance weekly. The Director of ES identified a sign off sheet for staff to complete emptied, however, it never filled up. The Director of ES stated cigarette butts could have plugged the stack because of the narrow opening, maybe the size of a 50 cent piece or little bigger. The Director of ES stated the facility disposed of the smoke stack ashtray in March when the facility no longer allowed anyone to smoke. On 7/1/20 at 10:14 AM, the owner of the Super 8 Motel stated he did not recall a resident from the facility dropped off at the motel on 12/17/19. The owner stated it occurred too long ago and his video recordings are only available for 4-5 days maximum. On 7/1/20 at 10:38 AM, the DON stated all staff received education prior to returning to work after the 12/30/19 education regarding elopement and smoking. The DON stated they also placed the Elopement policy in the communication/report books on the units at that time. On 7/1/20 at 11:58 AM, the MDS Coordinator stated Resident #1's base line care plan and comprehensive care plan should have stated the resident required assist of 2 staff to go outside to smoke when it was put into effect. The MDS Coordinator stated she knew verbally that Resident #1 required 2 staff, however, she thought the DON updated the resident's care plan. The MDS Coordinator stated when she went to the Super 8 Motel to get the Resident #1, she went directly up to the room to get her. The MDS Coordinator stated the front desk gentleman stated 2 people dropped her off. The MDS Coordinator stated she did not speak directly with the gentleman at the desk. The MDS Coordinator stated she did not update the Elopement book and did not know who was responsible, stated it was never clarified. On 7/1/20 at 1:32 PM, the DON stated during the elopement in service he discussed that Resident #1 no longer smoked and Resident #2 would continue to require constant supervision with smoking until they made further arrangements. On 7/1/20 at 3:25 PM, the DON stated the elopement education began on 12/30/19 and all staff completed education prior to working their next shift if they did not attend the meeting. The DON stated administration talked about the elopement, however identified no formal education prior to 12/30/19. On 7/1/20 at 4:17 PM, Staff L Medical Records confirmed she was with the MDS Coordinator and Staff M at the Super 8 Motel on 12/17/19 to pick up Resident #1. She did not talk to the gentleman at the front desk. Staff L stated she was just there, as all staff were looking for the resident. Staff L stated she did not know of anyone talking to the gentleman at the front desk. Staff L stated she suspected the white car picked Resident #1 up, as it was in the Super 8 parking lot with 2 females in it, however, Staff L did not go talk to them. On 7/1/20 at 4:22 PM, Staff M Former Facility Marketer confirmed she was with the MDS Coordinator and Staff L at the Super 8 Motel on 12/17/19 to pick up Resident #1. he did not specifically talk to the gentleman at the front desk. Staff M stated she did not recall if the gentleman stated the car dropped her off or if someone brought the resident inside. On 7/1/20 at 4:37 PM, Staff N CNA stated she took Resident #1 outside for a cigarette one time with another CNA. Staff N stated Resident #1 did not attempt to leave facility at that time. On 7/2/20 at 9:39 AM Staff O CNA, stated he took Resident #1 outside to smoke one evening around 7 PM to 8 PM with another CNA. Staff O stated Resident #1 stood beside them and never displayed any aggressive behavior or attempted to leave the facility. On 6/29/20 at 2:25 PM and on 7/1/20 at 9:00 AM, the surveyor observed the area where the resident eloped, along with Staff A CMA. Observation and description from the CMA, showed the area where the resident came out of the facilities east door onto the ramp and the resident stopped half way down ramp, approximately 5 feet. The distance the resident traveled from the end of the facility ramp to the busy intersection at Willis Street was approximately 35-40 feet, taking less than 30 seconds to travel. Abatement: The facility abated the immediate jeopardy on 12/30/19 when they educated staff on the elopement policy and procedure and that residents allowed to go outside to smoke would have constant supervision. This resulted in past noncompliance for the facility. As of 3/7/20, the facility became Smoke Free Facility and no residents are allowed to smoke. The facility was notified of the immediate jeopardy on 7/1/20.
F 0943 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected -** Few	**Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.** Based on employee file review, policy review, and staff interview, the facility failed to ensure 3 of 5 staff reviewed completed the Dependent Adult Abuse Training within 6 months of hire. The facility reported a census of 65 residents. Findings include: 1. Staff Q Certified Nurse's Aide (CNA) hire date 7/16/19. Dependent Adult Abuse Mandatory Reporter Training completed on 7/5/20. 2. Staff R CNA hire date 11/26/19. Dependent Adult Abuse Mandatory Reporter Training completed on 7/5/20. 3. Staff S Registered Nurse hire date of 6/26/19. Child Abuse Training completed 7/16/16. No documentation that Staff S completed the Dependent Abuse Adult Training. Policy and Procedure, Subject: Adult Abuse and Reporting dated 11/2018, revealed each new employee would receive the mandatory 2 hour Adult Abuse training with an approved trainer and course that includes Adult Abuse, mandatory reporting, and resident rights. On 7/6/20 at 1:24 PM, the Administrator stated she expected new hires to complete Dependent Adult Abuse training within 6 months of hire.