STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165270	A. BUILDING _____ B. WING _____	**07/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STRATFORD SPECIALTY CARE	**1200 HIGHWAY 175 EAST STRATFORD, IA 50249**

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	**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, staff and physician interview, the facility failed to provide adequate nursing supervision of residents when using the facility's courtyard patio, for 1 of 7 residents reviewed for inadequate nursing supervision (Resident #1). On 6/23/20, the facility began unlocking the courtyard patio door in the morning and locking it at night to allow residents to use the courtyard independently during the daytime. The facility failed to maintain adequate supervision of Resident #1 and did not know the resident entered the courtyard on 7/11/20. Staff last saw the resident at approximately 9:44 a.m. and did not see her again until staff found the resident at 10:20 a.m. on the ground following a fall. The heat index was 90 degrees outside at the time and when found, the resident's temperature was 101.4 degrees. It took 1 hour and 15 minutes for the resident's temperature to return to normal (98.4 degrees). The resident was also assessed with [REDACTED]. The incident resulted in an immediate jeopardy situation. The facility abated the concern on 7/18/20. The facility reported a census of 38 residents. Findings Include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 identified the resident with long and short term memory impairment. The resident's cognitive skills for daily decision making severely impaired. The MDS recorded the resident exhibited wandering behavior one to three days of the seven-day look back period. The MDS revealed the resident independent without set up for bed mobility and transfers. The MDS revealed the resident required extensive physical assistance of one person for toileting and frequently incontinent of urine, always incontinent of bowel. The MDS documented [DIAGNOSES REDACTED]. The care plan focus area initiated 5/25/18 identified the resident with difficulty making her own decisions. Care plan interventions revised on 10/12/18 included: give the resident verbal cues or reminders when she could not remember; the resident could follow simple directions, redirected easily; and sometimes the resident spoke words or sentences that made sense and other times she spoke jumbled words. Additional revisions to the care plan included: a. On 12/18/19, a key lock placed on the resident's closet doorknob as the resident used the closet as a bathroom and an alarm placed on the bathroom door as the resident flushed things down the toilet. b. On 2/1/19, the resident's clothes kept in the shower room because of her dementia and trying to flush them in the toilet. c. On 2/8/19, staff to redirect the resident as needed from wearing multiple layers of clothes at a time. A care plan focus area dated 5/25/18 identified inappropriate behaviors related to [MEDICAL CONDITION]. On 6/22/20, a care plan revision documented the resident resided on the securely locked CCDI (Chronic Confusion and Dementing Illness) unit and a 30-day trial to occur of opening the CCDI unit doors. A care plan focus area revised 7/12/20 identified the resident at risk for falls related to dementia and the resident fell without injury on 9/22/19, 10/16/19, 2/15/20, and on 7/11/20 with injury. The care plan interventions included: a. On 10/12/18 the resident on the falling leaf program, used a walker in her room and hallways, and at times needed reminders to use the walker. Staff to monitor for changes in the resident's condition that warrant increased supervision or assistance and notify the physician. b. On 7/11/20, a secondary alarm placed on the patio door and the alarm to be on at all times when the door unlocked. On 7/16/20, the intervention resolved. c. On 7/16/20 the door to the patio to be locked unless the patio used with supervision. Resident #1's order list revealed that on 12/24/18 the physician ordered CCDI unit placement for the resident. A fall risk evaluation dated 6/3/20 revealed the resident scored a 15; a score of 10 or higher equaled high risk for falls. A wandering risk evaluation dated 12/12/19 identified a score of 14.0; the 3/12/20 evaluation scored the resident at a 9.0; and the 6/3/20 evaluation scored the resident at 9.0. The score of 10 or higher indicated a high risk for wandering. Under 10 equaled low risk. Resident #1's supplemental documentation records documented the resident displayed wandering behavior on the following days: a. May 2020 - 5/1, 5/2, 5/3, 5/4, 5/5, 5/7, 5/8, 5/9, 5/10, 5/13, 5/14, 5/15, 5/18, 5/19, 5/22, 5/23, 5/25, 5/27, 5/28, 5/31 b. June 2020 - 6/1/, 6/2, 6/3, 6/5, 6/6, 6/7, 6/8, 6/10, 6/11, 6/13, 6/15, 6/16, 6/17, 6/19, 6/20, 6/22, 6/24, 6/25, 6/26, 6/27, 6/28, 6/29, 6/30 c. July 2020 - 7/3, 7/5, 7/8, 7/9, 7/13 Progress Notes included the following documentation: a. On 6/10/20 at 10:37 a.m., a care plan conference summary note under the nursing section recorded the resident continued to require assistance to meet ADL (Activities of Daily Living) needs and remained on the CCDI unit ambulating independently with a walker. b. On 6/22/20 at 7:04 p.m., the resident shut the memory lane doors after the doors opened two times. The resident stayed back in the TV room and did not go past the doors. c. On 6/23/20 at 7:05 p.m., the resident urinated in the recliner one time and staff assisted her to use the restroom to clean and change clothes. The resident later incontinent in bed and wandered into others rooms, slamming the door to her own room. d. On 6/24/20 at 1:10 p.m., the resident visibly upset, confused, resisting care, and spit her medication out. e. On 6/24/20 at 10:34 p.m., the resident redirected multiple times throughout the shift due to wandering into other peers rooms and taking items from their rooms. f. On 6/25/20 at 11:52 a.m., the resident in and out of every room taking all toilet paper off the rolls putting things in toilets. g. On 6/26/20 at 2:42 p.m., the resident wandered in other's rooms and went through their things, urinated on the bed two times, undressed two times, and behaviors increased since memory care unit doors opened. h. On 6/27/20 at 12:32 p.m., the resident incontinent and stripped off her clothes in the TV room, naked in the recliner. i. On 6/28/20 at 6:32 p.m., the resident wandered in halls and into others rooms. j. On 7/4/20 at 4:07 p.m., the resident slammed doors and wandered in the hallways. k. On 7/9/20 at 8:00 p.m. and 7/10/20 at 12:53 a.m., the resident up in hallway wandering halfway naked and went into other residents' rooms. The unwitnessed fall incident report dated 7/11/20 at 10:20 a.m. revealed staff found Resident #1 outside of the memory care unit dining room, on the patio. A CMA (certified medication aide) found the resident lying on her back in the mulch with the walker on top of her stomach. The nurse assessed two red lines on the resident's abdomen measuring in 15 cm (centimeters) by 2 cm, 7 cm by 2 cm, and a 10 cm diameter circle of redness on the resident's coccyx. The report recorded the resident's skin flushed and temperature 101.4 degrees (high). The resident assisted to her feet by three staff members. The resident could not give a description of the event. The incident report revealed the facility locked the door to the outside courtyard following the incident. The incident report revealed the facility notified the family and the physician. A Progress Notes dated 7/11/20 at 8:12 pm., written by Staff A, Registered Nurse (RN), documented Staff A called to the courtyard outside the memory unit dining room. Staff A recorded the resident found by a CMA laying on her back in the mulch with the walker on top of her stomach. Staff A assessed the resident as alert, awake, responsive to verbal stimuli, skin flushed, and sweating. Staff A measured vital signs that included temperature of 101.4 degrees and heart rate of 104 beats per minute. Staff assisted the resident to her feet then the resident walked with assistance of two persons to the restroom. Staff A documented the resident's temperature remained high, a cool washcloth place on the resident's neck but the resident refused to keep it on her forehead, and the resident refused to void at that time. Staff assisted the resident to change her clothes as the clothes sweaty, and the resident assisted to ambulate to her bed. Staff A further assessed 2 red lines on the resident's abdomen where the walker rested; the top line 15 cm by 2 cm and the bottom line 7 cm by 2 cm, which started to fade. Staff A assessed a 10 cm circle of redness on the resident's coccyx area from

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) laying on the warm mulch that was fading around the edges. Staff A measured the temperature at 10:28 a.m. at 101.0 degrees and at 10:35 a.m. at 100.7 degrees. Staff A offered the resident a glass of water, which she drank. Staff A initiated an intervention to keep the doors to the outside courtyard locked unless supervision available. Resident #1's Temperature Summary printed 7/17/20 documented the following temperature readings: a. 7/11/20 at 2:39 a.m. 98.0 degrees b. 7/11/20 at 10:21 a.m. 101.4 degrees c. 7/11/20 at 10:28 a.m. 101.0 degrees d. 7/11/20 at 10:39 a.m. 100.7 degrees e. 7/11/20 at 10:50 a.m. 99.6 degrees f. 7/11/20 at 11:03 a.m. 98.9 degrees g. 7/11/20 at 11:23 a.m. 98.8 degrees h. 7/11/20 at 11:36 a.m. 98.4 degrees The Progress Notes dated 7/13/20 at 8:32 a.m. documented a fax received from the resident's physician stated the physician would review the incident in-person on Wednesday (7/15/20). A physician fax form dated 7/11/20 documented a FYI (For Your Information) notification of Resident #1's unwitnessed fall in the courtyard off memory lane. The fax recorded the resident found on her back in the mulch, flowerbed, with no injuries. The fax documented the resident's temperature elevated initially but went down to normal. Then intervention implemented to have the doors closed to outside unless supervised. The physician responded 7/13/20 that she would discuss the incident on Wednesday (7/15/20) to review the incident report and policy. The Internal Quality Assurance Investigation Form, signed by the Director of Nursing (DON) and Administrator on 7/13/20, identified the possible contributing factors to Resident #1's fall on 7/11/20 as the cement higher than the ground. The facility implemented the following preventative measures: patio door to remain locked at all times unless supervision provided outside and staff educated about locking the patio door. Physician visit notes dated 7/15/20 identified the resident with a couple of significant events recently. The notes revealed the resident wandered out onto the patio that weekend and staff found the resident in the flowerbed. The entry documented apparently the resident's walker hit the edge of the sidewalk, which caused her to tumble. The resident did not have obvious injuries but did have an elevated temperature of 101.0 degrees Fahrenheit and the temperature managed in the facility. The physician found out about the incident by fax on Monday morning (7/13/20) and as of the 7/15/20 exam, the resident did not appear to have any injuries and appeared at baseline mentally. Progress Notes dated 7/16/20 at 10:17 a.m. documented after QA (Quality Assurance) discussion an intervention dated 7/11/20 of a secondary alarm to be on the courtyard patio door at all times when the door unlocked changed to the door locked unless supervision provided. Observations Observation showed on 7/15/20 at 10:30 a.m. the facility's courtyard located on the Memory Lane unit, off the unit's dining room. Observation also revealed the facility's CCDI unit doors open. Observation of the patio revealed uneven areas from the sidewalk to the mulch with drop of 2 to 3 inches. Observation also showed chairs present, small landscaping ornaments in the center circle, plants and shrubbery around the edges of the patio in mulch areas. On 7/15/20 at 1:36 p.m., the surveyor checked the doors for alarms and found the courtyard door locked. Observation on 7/16/20, revealed the resident's room located approximately four rooms down from the CCDI unit dining room which contained the entrance to the courtyard patio. Staff Interviews On 7/15/20 at 3:21 p.m., Staff A, RN, reported the resident occasionally wandered but tended to stay in her room and kept the door shut most of the time. Staff A, RN, recalled the incident of Resident #1 on 7/11/20. Staff A reported she assessed Resident #1 at 10:20 a.m. as she laid on the ground. Staff A stated prior to going on break at 9:45 a.m., Staff B, CMA, reported seeing the resident in bed. Staff A reported Staff B reported finding the resident at 10:20 a.m. on the ground of the courtyard upon returning from her break. Staff A stated there was no way the resident outside for more than a half hour. Staff A stated she observed skin issues on the resident which disappeared by the time she left the facility at the end of her shift. Staff A reported even though there was a staff member assigned in the CCDI unit, staff tried to help all over the building and cover where they could. However, at the time of the incident the CMA went to break. On 7/16/20 at 2:10 p.m., the DON identified the resident's general routine as walking in the hallway, the dining hall, and the TV room. The DON reported when the facility first opened the CCDI unit doors, the resident would actually shut them. The DON reported the resident loved to go outside, and went outside before. The DON reported the resident with no previous elopement events in the facility prior to the event. The DON stated the resident never tried to open doors or tried to leave the facility. The DON reported staff recalled seeing the resident 30 minutes prior to the fall. The event occurred around 10 a.m. The DON identified Staff B as the one to discover the resident down outside in the patio area. The resident's abdomen and buttock contained marks but the DON reported those skin issues now resolved. The DON reported before the incident, the door not alarmed. The DON reported staff checked door alarms daily and times for the checks varied The DON stated during the weekends, the weekend manager or scheduled department heads checked the doors. The DON identified the Dietary Manager as the department head working the weekend of 7/11/20. The DON stated night shift did not always open the doors in the morning for residents. The DON reported when the department heads did the door checks, typically in the morning around 8:00 a.m., they unlocked the patio door at the same time so residents could utilize the courtyard. The DON reported the facility applied a secondary alarm which proved to not work so staff now locks the patio door and staff must be supervise residents while outside. On 7/16/20 at 2:39 p.m., the DON reported she called Staff A at 2:30 p.m. and got a statement from Staff A. The DON reported Staff A said she chose to fax the doctor due to the resident not having any major injuries and because all skin issues resolved before Staff A left the facility. The DON reported Staff A said the resident wore slacks and a short sleeve shirt when found. The DON reported the facility did not have a facility policy for use of the courtyard. The time sheet for 7/11/20 revealed Staff B clocked out for break at 9:44 a.m. and returned at 10:15 a.m. On 7/16/20 at 4:45 p.m. Staff B, CMA, recalled Resident #1's fall on 7/11/20. Staff B reported she checked on the resident previously and observed the resident in her room, in bed and awake. Before going to break at 9:44 a.m., Staff B informed other staff the residents doing okay. Staff B reported she left for break and returned to find the resident outside in the courtyard around 10:20 a.m. Staff B stated she observed the resident damp from sweat and wearing beige pants, a t-shirt and shoes. Staff B reported Resident #1 normally wandered and wandered in and out of resident rooms. Staff B reported she felt staff should be in the CCDI unit at all times to supervise the residents. Staff B reported residents like Resident #5 and Resident #6 tried to elope. Staff B stated she felt the facility had residents who were high acuity and required more help. In a follow-up interview on 7/20/20 at 12:50 pm, Staff B reported she did not feel it safe for Resident #1 to be outside unsupervised. She stated she used to take the resident out to the patio all the time and would always supervise her. Staff B reported she didn't know the door was unlocked to the patio. Staff B identified the patio door as unlocked by the time the resident went out in the courtyard. Staff B stated she found the resident outside and the resident stated, oh good you came. Staff B reported the resident appeared alert and laid flat on her back in the center of the patio, which was covered in mulch and lawn ornaments. The resident laid with her walker but did not appear to be laying on any of the landscaping ornaments located in the center of the patio. In a follow-up interview on 7/21/20, Staff B reported the resident also outside on 7/11/20 at around 9 a.m. Staff B let Resident #1 out to the patio and the resident stayed out there for about 5 to 10 minutes before wanting to come back in. On 7/21/20 at 10:38 a.m. Staff D, CMA, recalled the fall on 7/11/20 for Resident #1. Staff D reported she first saw Resident #1 on 7/11/20 around 9 a.m. when Staff B asked her to let Resident #1 inside from the patio while Staff B worked on medications. Staff D reported the resident outside and waved to get back in. Staff D reported she knew the door unlocked but did not know when the door became unlocked. Staff D reported, later she headed to lunch when she heard a page overhead for urgent help in CCDI unit. Staff D put her items down and went to help in the unit. Staff D reported she arrived to see Resident #1 on her back in the middle of the courtyard in the mulch area. Staff D stated the resident didn't seem to be in any distress or complain of pain. Staff took the resident's vitals and staff assisted her up. Staff D reported the resident had red areas to the resident's backside, which appeared to be from lying on the mulch. Staff D didn't recall seeing the resident's abdomen for marks but the resident's arms appeared pink. Staff D reported she assisted the resident to her feet. On 7/15/20 on 3:12 p.m., Resident #1's physician reported she received a fax 7/13/20 about Resident #1's fall in the courtyard 7/11/20. The physician stated she understood the courtyard was unlocked and staff found the resident outside on the mulch area of the patio. The physician reported she called the doctor on call over the weekend to find out whether or not the facility reported the incident to them and the doctor stated the facility did not report it to them. The physician reported she felt the facility should have notified the on-call physician about the incident. The physician commented she discussed with the facility that they needed to make changes regarding physician notification. In a follow up interview on 7/16/20 at 4:13 p.m., Resident #1's physician reported she came to the facility on [DATE] and assessed the resident with no signs of skin breakdown or wounds from the fall. The physician reported she expected the facility to call if a resident temperature 101.4 degrees but she felt okay to treat the resident within the facility since hospitals battling COVID-19. The physician stated she would not want the resident to risk exposure. The physician stated if the temperature had been 103 degrees, she would have expected a call and a transfer to the hospital. On 7/16/20 at 1:48 p.m., the climatologist reported the temperature for the nearest city, Webster City, recorded on 7/11/20 at 9 a.m. as 82 degrees with a humidity of 66%, heat index 86 degrees. At 10 a.m. on 7/11/20 the

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) temperature 84 degrees with a humidity of 70%, heat index 90 degrees. On 7/15/20 at 1:40 p.m., the Maintenance Director stated the gate outside in the patio didn't lock but identified it as alarmed. The Maintenance Director stated he was not in the facility when staff found the resident outside. The Maintenance Director stated on days he worked he checked the doors to make sure they were functioning properly and would unlock the patio door during the daytime for the residents. On 7/15/20 at 3:45 pm, the Dietary Manager (DM) reported night staff should lock the doors and when she came in the mornings, she did the patio door check and unlocked it for the residents. The DM stated after the incident occurred with Resident #1 on 7/11/20, she checked the patio door at 10:30 a.m. The DM stated she did not unlock the door that morning. The DM identified it as likely the overnight staff left the door unlocked. The DM reported the door now contains a secondary lock or alarm so when residents go outside the alarm goes off. Observation with the DM at the time of the interview showed now a secondary lock on the patio door. The Dietary Manager showed when the door unlocked, the alarm would sound which required a staff member to shut it off with use of a key. On 7/16/20 at 4:30 p.m., Staff E, CNA (Certified Nurse Aide), reported when the facility first opened the doors to the CCDI unit, Resident #5, attempted to leave through the front door of the facility. She stated the facility since started opening the door to the patio for Resident #5 to go outside instead of trying to escape through the front door. Staff E stated management preferred to have the CCDI unit doors open. Staff E reported the night staff supposed to lock the patio door at 10 p.m. Staff E reported even though there was a schedule with designated areas for staff to work in, they technically floated all over the facility to help where they could. Review of the facility staff schedule revealed there were usually two nurses on in the morning with four CNAs to cover the building. On the morning of 7/11/20 (day of incident) the schedule revealed one nurse scheduled for the whole facility and four CNAs, one acting as a med aide. This indicated the facility was short one staff. Facility Educations The Five Minute Meeting for Employees dated 6/22/20 contained 22 staff signatures and recorded the following information: Memory Lane doors are now open for the 30-day trial period. The first week we will keep operations the same. Medication aide will work in memory lane and continue to do meds. Start of the second week we will make the transition of the nurse responsible for the medications down memory lane. The CNA/CMA in memory lane work the right hall and memory lane (also known as left hall) CNA duties. The Five Minute Meeting for Employees dated 6/23/20 contained 22 staff signatures and recorded the following information: Memory lane patio doors will be unlocked by maintenance or whoever is checking door alarms for that day. If they forget to unlock nursing, please unlock. Also, relock the doors during inclement weather. Nurses are responsible for ensuring the door is locked at 10 p.m. Additional Staff Interviews On 7/16/20 at 1:50 p.m., the MDS Coordinator reported the facility began the trial of opening the CCDI memory care doors on 6/22/20. The MDS Coordinator stated she made note of the trial on all residents care plans who resided on the CCDI unit. The MDS Coordinator responded all staff could work everywhere in the building and not just dedicated to the memory care hall. At 3:00 p.m., the MDS Coordinator responded to the question what actions the facility took to increase supervision of residents who resided on the memory care unit when the facility opened the memory care doors on a trial basis. The MDS Coordinator stated they mostly kept a CMA on the unit with the doors locked and then when they opened doors that directed an aide to focus on that hall. The MDS Coordinator reported when the memory care doors locked and secured there were three residents who ambulated independently and utilized the courtyard: Resident #5, Resident #6, and Resident #1. The MDS Coordinator stated they placed a wander guard on Resident #5 when they opened the doors. The MDS Coordinator stated they tried to figure out what to do with the patio door located on the memory care unit that lead outside to a locked courtyard. The MDS Coordinator stated in the past, the facility tried several different approaches from having the patio door unlocked thru the day then locked at night and a time when they had a secondary alarm on the door. The MDS Coordinator stated the med aide could work on the unit and would lock the door. Then they went to having the door locked at all times. The MDS Coordinator responded the actions taken to increase supervision when they decided to open the CCDI doors included updating the care plans that a trial of opening the doors took place and if a resident went outside to the courtyard they needed supervised. At this point in the interview, the DON joined the conversation. The DON stated in preparation for opening the CCDI unit doors the facility notified all physicians, notified families, and completed elopement assessments for the six residents who resided on the CCDI unit. The DON stated the outside doors of the facility contained wander guard alarm systems. The DON commented the facility took baby steps when opening the doors. The DON stated they first kept someone staffed on that hall the whole time. Then they had a couple of residents who never crossed the line and Resident #1 as one of those residents who still did not come off that hall. The DON said eventually as the residents began to venture off that hall so did the staff assigned to the hall. The DON responded to what led the facility to trial opening the memory care doors. The DON identified the population on the CCDI unit as only six residents. The facility did not get referrals or admits to the unit, they did not feel those six residents presented as elopement risks, and they wanted the hall available to place residents if they had an outbreak of COVID-19 infection in their building. The DON stated those residents who scored higher on the elopement risk assessments had a wander guard placed on them. The MDS Coordinator responded to why the facility scored Resident #1 a low risk on 6/3/20 when she previously had been high risk on 12/19/19 quarterly assessments. The MDS Coordinator and DON stated the resident did not leave her room anymore and typically just went to the commons area to watch her westerns on TV and at one time resided with the general population after a hip injury . They stated Resident #1 got better and then wandering progressed so went back to the unit. Therefore, at that time, Resident #1 score a higher elopement risk score. The DON added the increased supervision when opening the doors was just like any other monitoring of residents they did and they gave adequate supervision. They kept the same daily staffing ratios--- that did not change. On 7/17/20 at 2:06 p.m., the Nurse Consultant stated the facility did not have a policy or procedures available for the use of the courtyard or expectations on the locking of the courtyard patio door. On 7/17/20 at 2:10 p.m., the Administrator stated she did not know the date the courtyard patio door opened. The Administrator said that in the winter the facility kept the door locked at all times. The Administrator recalled the QA team discussed unlocking the courtyard patio door about a month or two prior related to the previous summer they unlocked the door to give residents secured access to the outside. The Administrator commented they decided to unlock the door in the mornings. The Administrator responded anyone with a key could unlock the door, nurses or anyone who checked door alarms. The Administrator stated during the week, first thing in the morning, the Maintenance Director unlocked the door, and on weekends, the manager on duty unlocked the door. The Administrator identified no set time to lock the courtyard door at night but revealed the night nurse as responsible to lock the door. The Administrator reported the DON talked to the nurses and did not know whether she provided the education verbally or written. The Administrator responded the facility did use temporary staffing agencies for CNA help but not for nurses and the Administrator did not know if the DON educated them. The Administrator voiced only the medication aides and nurses would have keys to the door. The Administrator responded she had no expectation for staff to provide supervision when the residents went in the courtyard. The residents who ambulated independently did not need supervision. The Administrator stated she started working at the facility in November 2019 and she did not know of Resident #1 having a fall since then. At this point in the interview, the DON joined the conversation. The Administrator then confirmed the facility unlocked the courtyard patio door on 6/22/20 at 8:00 a.m. and did not believe they made any changes to policies. The Administrator stated on 7/11/20 when Resident #1 fell , the facility locked the patio door unless staff provided supervision when a resident went outside. The Administrator stated she believed before that a resident did not need supervision when using the courtyard. The DON stated when the facility opened the memory care unit doors the supervision remained one staff member staffed on that hall, staff completed shift and behavior charting, and the facility did not feel any of those residents met the criteria for a locked unit. The DON stated it would not matter if the memory care doors opened or closed, Resident #1 could always go outside to use the courtyard patio. The Administrator responded she first became aware of Resident #1 falling outside on 7/11/20 when she read notes in risk management the morning of 7/13/20. The Administrator stated they discussed initially just locking the door then thought maybe they could put on a secondary alarm, however, the alarm went off too many times from residents opening the door. The Administrator said they then changed protocol for the courtyard patio door locked at all times and they made all those changes on 7/13/20. On 7/17/20 at 3:36 p.m. Staff F, Licensed Practical Nurse (LPN), recalled working with Resident #1 on 7/11/20 in the evening. Staff F identified Resident #1 as agitated when she tried to get vitals, the resident did not complain of pain, but its hard to say with dementia residents. Staff F stated the resident usually wandered at night into peoples' rooms and took stuff out. Staff F reported that night the resident stayed in her room. Staff F could not identify if the resident was a fall risk. Staff F recalled a 5-minute meeting about keeping the patio door open. Staff F voiced she did not agree with that as it was hard to keep track of residents with the doors opened and residents wandered a lot when sundowning. (According to

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(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) mayoclinic.org, sundowning refers to a state of confusion occurring in the late afternoon and spanning into the night. Sundowning can cause a variety of behaviors, such as confusion, anxiety, aggression or ignoring directions. Sundowning can also lead to pacing or wandering.) Staff F responded facility management knew of the concern as they talked about it a lot. Staff F stated management staff never asked the floor staff about what they experienced at night with some residents up in the middle of the night several times. Staff F voiced yes the residents from the CCDI unit wandered and with the CCDI doors opened, residents appeared more confused and some really exit seeking. Staff F commented when the CCDI doors were shut, there was less risk as they always had a staff member assigned to that area. Staff F stated the person assigned the memory care hallway is now expected to help on other halls for people who need more care. Staff F identified the courtyard patio door as always locked at night and thought it locked the night of 7/10/20 as she usually went to check. Staff F responded the nurses kept the key to the patio door and the med aide also had a key as the med aide is responsible to ensure the door locked at night. Staff F stated usually Staff H, CNA, worked on memory care hallway and check
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to implement transmission based precautions for a resident with acute respiratory symptoms/symptoms of COVID 19 for 1 of 3 residents reviewed (Resident #8). The facility also failed to ensure staff followed infection control practices and properly disposed of contaminated personal protective equipment (PPE) in order to prevent or reduce the risk of spreading infection and disease for one of thirty-eight residents observed. The facility reported a census of 38 residents. Findings Include: 1. A Minimum Data Set (MDS), with a completion date of 7/13/20, for Resident #8, listed [DIAGNOSES REDACTED]. The Brief Interview for Mental Status (BIMS), documented 15 out of 15 indicating cognitively intact. The MDS documented the resident as being independent with activities of daily living (ADL's). A Follow up Question Record dated 7/14/20 at 12:22 AM, revealed the resident exhibited symptoms of a new cough, fever greater than or equal to 100.0 or chills, headache. (Symptoms of COVID 19) Progress Notes: 7/13/20 at 6:32 PM, the resident complained of not feeling well since last night. Complained of a cold, headache, and reported a cough with yellow brown sputum with a temperature of 99.5. 7/14/20 at 1:38 AM, focused evaluation due to change in condition, fever greater than or equal to 100.0 or chills, headache, and new cough. Resident complained of new cough with yellow brown sputum, headache, and chills. Temperature 99.5. Notified the residents' primary care provider. 7/14/20 at 4:46 PM, focused evaluation due to change in condition and new cough. The resident reported occasional productive cough with yellow sputum. 7/14/20 at 11:05 PM, order note. Received new orders from the residents' primary care provider due to complaints of cough, chills, and headache. Order for [MEDICATION NAME] (Z-Pak an antibiotic widely used to treat infections of the lungs and throat) and [MEDICATION NAME] (steroid used to treat inflammation, mucus production, and breathing disorders). 7/14/20 at 12:07 AM, focused evaluation due to antibiotic use, change in condition, fever greater than 100.0 or chills, headache, new cough, and new physician order. Temperature 98.9, resident reported productive cough with light brown colored sputum. 7/15/20 at 4:59 PM, focused evaluation due to antibiotic use and upper respiratory infection with resident temperature 99.2. Document dated 7/19/20 sent to the residents primary care provider documented common cold with stuffy nose, nasal congestion, and dry cough; with antibiotic Z-Pak listed. The primary care provider documented the resident had a history of [REDACTED]. Document titled Coronavirus Disease (COVID-19) Preparedness Checklist for Nursing Homes and other Long Term Care settings, undated, identified the facility with infection control Transmission Based Precautions policies that directed staff in the care of residents with respiratory infection. Document titled Care Initiatives' Infection Control Manual dated April 2018, revealed a resident with infection of severe acute respiratory syndrome should have airborne, droplet, contact, and standard precautions in place. The document provided guidance for barriers to be utilized: Standard = gloves for touching blood, body fluids, secretions, excretions, and contaminated items. Gowns to prevent soiling of clothing from splashes or sprays of blood or body fluids. Mask, eye wear, face shield during procedures and resident activities that are likely to generate splash or spray of blood or body fluids. Contact = gloves when entering the room. Gowns when entering the room if contact with resident or environmental surfaces, or items in the resident room is anticipated. Droplet = in addition to standard precautions, use masks when working within 3 feet of the resident. Airborne = in addition to standard precautions, wear respiratory protection when entering the room. On 7/20/20 at 9:38 AM, the Director of Nursing (DON) stated the resident was not placed in isolation due to the resident's temperature not being 2.2 degrees above normal, however, the DON confirmed the resident had complained of new cough and headache. On 7/20/20 at 11:58 AM, the DON stated facility staff did not utilize additional personal protective equipment (isolation barriers) when the resident initially complained of new cough and headache on 7/14/20. On 7/20/20 at 2:49 PM, the Administrator stated she would expect staff to notify herself, the DON, and the residents' primary care provider, and place the resident in isolation with symptoms of upper respiratory infection. 2. During observation on 7/13/20 revealed the following: a. At 3:30 p.m., a sign hung on the door of room R-2. The sign indicated the resident on quarantine and droplet precautions. Another sign indicated a gown, N95 mask, faceshield and gloves worn whenever entered this resident's room. b. At 3:55 p.m., Staff C, Certified Nursing Assistant (CNA), obtained a plastic bag from a storage slot at the nurse's station. Staff C walked to room R-2, removed a gown from the plastic bag, and donned the gown and a faceshield, then entered the resident's room (R-2). c. At 4:02 p.m., Staff C, CNA stood by the doorway of R-2, removed the isolation gown, rolled the gown into a ball, and placed the gown and faceshield into a plastic bag. Staff C took the plastic bag with the gown and faceshield and placed it in a slot labeled with his name at the nurse's station. d. At 5:30 p.m., observed several plastic bags inside individual slots by the nurse's station. The slots had staff names listed by them. The plastic bags had an N95 mask, faceshield, and a gown. During an interview 7/13/20 at 5:00 p.m , Staff A, CNA, reported when a resident in droplet isolation, she had to wear a N95 mask, faceshield, gown, and gloves. Staff A reported she removed the gown and gloves in the resident's room after use, and hung the gown on a hook in the resident's room. Staff A stated at the end of the shift, she placed the gown in a plastic bag, and stored the bag with the gown and faceshield/ N95 mask in a slot with her name on it at the nurse's station. Staff A reported she wrote the resident's room number on the gown and kept a separate bag with her name for each resident on isolation. Staff A stated she disposed of the gown after the resident's isolation or quarantine period discontinued, a minimum of 14 days. Staff A reported they didn't have enough gowns, so they had to re-use the gowns. Staff A also reported she wore the same N95 mask when took care of residents in isolation. During an interview 7/13/20 at 5:35 p.m., Staff B, Registered Nurse, reported the slots with staff names by the nurse's station were used to store isolation gowns, N95 masks, and faceshields after staff had used them in an isolation room. Staff B stated staff left the gown in the resident's room during the shift but then removed the gown, N95 mask, and faceshield, placed the items in a plastic bag, and stored the PPE in a slot at the nurse's station if staff not scheduled to work the next day or for several days. Staff B explained this was their way of preserving PPE, and what the staff had been told to do. During an interview 7/13/20 at 6:45 p.m., the Director of Nursing (DON) reported she was also the infection preventionist. The DON reported residents placed in quarantine and isolation precautions whenever they left the facility and returned. The DON reported a COVID-19 test performed at the hospital, but no further COVID-19 test performed unless a resident had symptoms of respiratory illness or had a fever. The resident in droplet precautions presumed positive for COVID-19. The DON reported she expected staff don a gown, gloves, N95 mask, and faceshield whenever staff cared for a resident in droplet precautions. The DON stated she expected staff remove the gown and place in a plastic bag at the end of their work shift, and place it in the slot by the nurse's station. When a resident's quarantine or isolation period ended, the staff then disposed of the gown. The DON reported they had found a way to store the used gowns in order for staff to re-use them, and for preservation of supplies. During an interview 7/13/20 at 7:00 p.m., the Administrator reported they didn't have enough gowns for staff to change out every time they entered an isolation room due to the number of residents in quarantine. The Administrator confirmed they had three residents on droplet precautions due to the residents had left the facility and returned to the facility, and presumed positive for COVID-19 A facility policy dated 4/2018, titled Droplet revealed residents who had known or suspected of infection with microorganisms transmitted by droplets generated during coughing, sneezing, talking, or during cough-inducing procedures. A mask worn within three feet of the resident, in addition to wearing PPE for standard precautions. A facility policy dated 4/2018, titled Contact revealed gloves worn whenever entered a resident's room. A gown worn when entered the resident's room if contact with the resident or environmental surfaces, or anticipated contact with items in the resident's room. A facility Infection Prevention and Control policy dated 2019 revealed the following procedural steps for doffing of PPE: a. Remove gloves and discard into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165270	A. BUILDING _____ B. WING _____	**07/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STRATFORD SPECIALTY CARE	**1200 HIGHWAY 175 EAST STRATFORD, IA 50249**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) waste container b. Remove goggles and faceshield and place in waste container. c. Unfasten ties on gown and pull gown away from the neck and shoulders, touching only the inside of the gown. Turn gown inside out and fold or roll into a bundle and discard. d. Grasp the bottom then the top ties or elastic straps and remove mask. Dispose of mask properly.