STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165149	A. BUILDING _____ B. WING _____	**06/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROWLEY MEMORIAL MASONIC HOME	**3000 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 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 observations, clinical record review, policy review, and staff interview the facility failed to adequately supervise residents in a secured unit by propping open a locked door leading into the courtyard for 1 of 3 residents reviewed. Staff were unaware the resident was in the courtyard or that he had climbed with fence. The facility reported a census of 27 residents. Findings include: Resident #2's Minimum Data Set (MDS) with a completion date of 5/17/20, listed [DIAGNOSES REDACTED]. The Brief Interview for Mental Status (BIMS), documented an 8 out of 15 indicating moderate cognitive impairment. The resident required limited assist of 1 staff for bed mobility, transfers, and ambulation. Care Plan: A Care Plan focus area with initiation date of 2/25/20 identified the resident at risk for wandering/elopement related to [DIAGNOSES REDACTED]. Interventions included: the resident wore wander guard activated to his call pendent/bracelet and with directions for staff to check for placement and functioning every shift, and use distraction if resident exit seeks. The care plan was updated to include the following interventions: staff to monitor and document exit seeking behavior (6/3/20), contact family if exit seeking (6/3/20), and the resident not to be in courtyard unsupervised (6/1/20). A Wandering Risk assessment dated [DATE] with lock date of 2/26/20, identified the resident as high risk for wandering due to orientation, behavior/mood, mobility, diagnosis, medications, and being a known wanderer. An elopement risk quarterly screen tool dated 5/15/20 with a lock date of 6/3/20, identified the resident at high risk for wandering due to talking of going home, goes to door with belongings, and waits at door for someone to come. An incident report dated 6/1/20 at 2:45 PM, with revision date of 6/10/20 at 8:15 AM, revealed staff leaving the facility at the end of their shift,observed the resident walking on the facility service entrance road. The report revealed staff observed the resident between 2:36 PM to 2:45 PM. The resident stated he tried to find the Dairy Queen to get a shake and to see his wife. Further investigation discovered staff opened the door leading to the secured courtyard to let in fresh air. Investigation of the resident's mental status revealed the resident orientated to person only. The incident report revealed no predisposing environmental factors related to the situation. Predisposing situation factors were not assessed. Prior to the incident, the resident did speak of going home Review of progress notes revealed no documentation of an assessment of the resident upon return to facility following the elopement. After the surveyor questioned lack of an assessment from the Director of Nursing (DON), review of progress notes revealed a late entry dated 6/1/20 at 3:30 PM, created 6/10/20 12:35 PM that identified the resident left the facility at 2:45 PM and located at the end of the service entrance drive on the property. Staff redirected the resident back into the facility. Staff observed 4 small bruises to the resident's right forearm and no other injuries noted. The entry did not contain assessment of vital signs. Review of document titled Courtyard Monitoring Guidelines with a date of 8/11/06, directed: Courtyard doors and other exit doors are alarmed Patients determined to be cognitively impaired are not permitted to go outside unless accompanied by staff or family member Designate a staff member to conduct at least every 30 minute checks of the resident in the designated outside area Review of updated document titled Courtyard Monitoring Guidelines undated after 6/1/20 elopement, directed: Courtyard doors secured at all times All secure unit residents must have consultant staff supervision when outside Patients determined to be cognitively impaired are not permitted to go outside unless accompanied by staff or family member On 6/10/20 at 3:30 PM, the Director of Nurses (DON), identified courtyard monitoring guidelines dated 8/11/06, in place when she began employment at the facility in August 2019. In November or December 2019 the guidelines changed in regards to the door locking and alarm system. The DON stated stated she did not think to change the guidelines after the November/December 2019 changes. The DON stated it was normally okay for residents to go out to the courtyard with 30 minute supervision checks. The DON revealed the facility did not have a missing resident or elopement policy. Review of document titled Resident #2 Elopement 6/1/20: Room temperatures checked How long door was propped open, was left blank Temperature of resident, make sure he is not overheated was left blank with check mark beside. Head count completed B and C halls-A did not contain present documentation Doors checked on all 3 halls to make sure locked Tech of Ages (computer software company for call system) coming to facility 6/2/20 On 6/11/20 at 9:50 AM, the Administrator, confirmed she completed the form, titled Resident #2 Elopement 6/1/20. She checked room temperatures due to staff complained the secured unit felt too hot. The Administrator stated she did not complete the section regarding how long staff propped the door open because she did not know. The Administrator confirmed staff did not document Resident #2's temperature/vitals signs. She stated she believed the DON told her the residents' temperature was fine and he was fine. The Administrator stated she contacted Tech of Ages and they could not determine how long the door had been propped open. Policy: During Entrance Conference on 6/10/20 at 9:52 AM with the DON and Administrator, the DON stated she did not know if the facility had a policy regarding elopement and missing resident, however, would look into it. During interview on 6/10/20 at 3:30 PM the DON continued to state they did not have a policy regarding elopement and missing resident, however, provided copy of a policy titled Wandering Device Placement Procedure dated 6/2016 with revision date of 2/18/20. During interview on 6/15/20 at 10:35 AM the surveyor questioned DON regarding the abatement plan submitted to the Department of Inspections & Appeals on 6/12/20, which stated the facility reviewed and updated their Elopement/Missing policy. The facility also updated policy to include direction to staff to complete a physical assessment/focused assessment and pain/skin/elopement assessment. When questioned on 6/11/20, the DON again stated the facility did not have a specific elopement/missing resident policy. On 6/15/20 at 10:45 AM the DON brought the surveyor a copy of the Elopement/Missing Resident policy dated 4/1/08 with revision date 4/2009. The DON stated she could not help what other people have taken out of her policy book. She identified she got the policy from corporate today. This indicates the facility did not have an elopement/missing resident policy onsite until 6/15/20 Observations on 6/10/20 at: 10:57 AM, revealed the resident laid in bed, eyes closed and television on. Call pendent/bracelet on left wrist 1:43 PM, the resident observed lying in bed watching television 2:51 PM, the resident laid in bed with eyes closed, call pendent/bracelet on left wrist Observations on 6/11/20 at: 7:54 AM, the resident sat on the edge of bed eating breakfast 10:06 AM, the resident laid in bed with eyes closed and hands clasped at chest and not able to identify call pendent/bracelet. Staff A, Certified Medication Aide (CMA), confirmed the resident did not have call pendent/bracelet in place. At 10:40 AM, Staff B, Licensed Practical Nurse (LPN), stated when she placed a new bracelet on the resident, he stated you found it. The LPN informed the resident it was a new bracelet and he stated his was in the mailbox by the entrance door to the unit. Staff B LPN, stated his bracelet was in mailbox. Staff B LPN was able to provide documentation that the resident's bracelet was checked for placement on 6/11/20 at 7:39 AM. Observation on 6/15/20 at: 9:48 AM, the resident laid in bed with call bracelet on left wrist. Staff C LPN, activated the call button on the bracelet and confirmed on computer screen at nurses' station that it activated in the residents' room. Interview on 6/10/20 at 11:50 AM, the DON stated the resident did not actively exit seek the day he eloped. The DON stated the resident made comments about leaving the facility and/or waiting for his spouse. The DON stated

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) since the resident eloped he experienced increased behaviors. The DON stated the resident went to the courtyard in the past, usually a couple of times a week and walked on the path, sat by the door, and then returned inside the facility. The resident went to the courtyard without staff being present unless the activity department went outside with another resident. Interview on 6/10/20 at 12:57 PM, Staff D Housekeeper, stated she observed the resident walking on the path in the courtyard at approximately 2:10 PM. At that time, the resident wore his winter coat. The housekeeper stated as she left work, she observed the resident walk down the service entrance drive by the facility sign. Staff D stated she called the DON at 2:48 PM to inform the DON the resident was outside and followed procedure to bring the resident back to the facility. Staff D stated the resident did wear his winter coat when found and he laid on his bed following return inside. Staff D stated the resident appeared upset upon return. Staff D stated staff propped the door to the secured open due to hot temperatures in the unit. On 6/10/20 at 2:57 PM, Staff E Admissions Coordinator, stated when the resident returned to the facility, he told her how he got out of secured courtyard. Staff E stated the resident explained he stepped on the bottom of the fence with one foot and with the other foot, stepped up onto the concrete ledge under the window and went over the fence. Staff E stated the resident appeared pleasant upon return. On 6/10/20 at 3:10 PM, Staff H Registered Nurse (RN), stated she completed a brief body assessment on the resident upon return to the facility, however did not know if she documented in the nurses notes. Staff H stated if she did not chart the assessment, she should have. Staff H stated she did not take his vitals at the time she completed the body assessment. Staff H stated the resident appeared frustrated upon return to the facility and informed staff he would do it again. On 6/10/20 at 4:04 PM, Staff F CMA, stated she last observed the resident at approximately 2:10 PM, standing by his bedroom door, when she left unit to take out garbage. Staff F stated the resident appeared upset. Staff F stated she frequently observed the locked door to the secured courtyard propped open to let air in. On 6/1/20 she observed the secured courtyard door propped open off and on throughout the shift due to feeling it was cooler outside than inside. The CMA stated maintenance stated he adjusted the thermostat, however, stated it continued to feel extremely hot. Staff F stated at approximately 1:30 PM she called the Administrator in her office (using speaker phone) so the resident could talk with her. The Administrator informed him she would call him back or come to the unit to visit with him. The resident sat by the phone for approximately 25 minutes, waiting for her to return call and appeared upset that the Administrator did not return his call or come to the unit to speak to him. On 6/10/20 at 4:36 PM, Staff G Certified Nurse's Aide (CNA), stated staff working on the secure unit on 6/1/20 requested the temperature turned down due being hot. Staff G stated the resident appeared upset due to the Administrator not calling the resident back or coming to visit him. Staff G identified the last time she saw the resident as approximately 1:45 PM, when he sat by the phone at the nurse's station. Staff G stated she assisted another resident in their room with the Hospice nurse at approximately 2:05 PM. Staff G stated revealed she should have completed rounds with the oncoming aide at that time, however, her replacement aide did not arrive and she assisted the Hospice nurse. Staff G stated when she exited the other residents' room at approximately 2:45 PM, she left the unit. On 6/11/20 at 7:39 AM, Staff C RN, identified herself as the nurse on duty the morning of 6/1/20. Staff C stated she did not see the resident since approximately 10 AM. The RN stated following the resident returning to the facility, she went to the secure unit to complete a head count of all the residents and the oncoming RN Staff H, told her she took care of everything. On 6/11/20 at 8:35 AM, the State climatologist reported the temperature on 6/1/20 between 2:30 PM to 3:00 PM was 91 degrees with south/southwest wind 30 miles per hour (mph) and gusts of 38 mph. The courtyard monitoring guidelines document contained a heat exposure table dated 8/11/06 that identified with actual outdoor temperatures between 90 to 104 degrees placed the resident at risk for heat stroke, heat cramps and heat exhaustion possible with prolonged exposure or physical activity. On 6/11/20 at 2:42 PM, the DON stated the CNA's are to complete walking rounds at shift change. The DON stated CNAs walk the halls and discuss any changes with the residents. She did not know if the CNAs actually went room to room. On 6/15/20 at 10:03 AM, the DON stated she did not know staff propped open the locked exit door to the secured courtyard. The DON revealed staff should not prop open doors due to the fire code, however, the secured courtyard was locked and she never thought a resident would go over the fence. The DON stated when staff let residents out alone, they would visually check on them every 30 minutes or sooner. On 6/15/20 at 10:17 AM, Staff F CMA stated facility administration knew staff propped the locked door to the secured courtyard on the CCDI unit. Staff F stated she was not concerned about residents going out to the courtyard without staff knowing because staff only propped the door open when staff were in the main lobby/dining area. The door was not left open unattended. Staff F stated when she took garbage out at approximately 2:15 PM, Staff G and the Hospice nurse sat in the main lobby/dining area and door was propped open. The CMA stated when she returned to the unit, she went to the medication room for narcotic count with the oncoming RN (Staff H) around 2:30 PM. The CMA stated once they completed narcotic count, both staff went out to main lobby/dining area and observed the locked door propped open with no staff present. Staff F stated she completed her shift and did not know the whereabouts of Resident #2. On 6/15/20 at 11:48 AM, the MDS nurse/Interim Administrator stated she observed the locked door leading to the courtyard on the morning of 6/1/20, and observed it propped open. She stated at that time, staff complained the unit felt too hot. She stated at that time, she informed staff they could not prop the door open, and that they needed to notify the Administrator or Maintenance about temperature concerns. She stated she did not see staff shut the door while in the secure unit. She stated she did not have concerns regarding residents going out to the courtyard independently with the door propped open because it was secured. On 6/15/20 at 11:53 AM, Staff H RN, stated she did take the resident's vital signs upon return to the facility following the elopement. Staff H stated she did not take them when she did the quick body assessment, however, she completed vital signs shortly after that maybe around 3 PM. Staff H stated she completes vital signs on all residents at the beginning of the shift for COVID assessment and then documents on the log sheet. A resident screening for infection sheet identified the date as 6/1/20 with no time listed. The sheet revealed the resident's temperature as 97.9 degrees, pulse 117, respirations 20 and oxygen saturation 95%. On 6/11/20 at 8:30 a.m. the surveyor observed the area and where the resident indicated he eloped. Observation showed the area where the resident went over the fence was at the corner of the court yard and building. The resident informed staff he stepped on the bottom rail of the fence and concrete window sill, which the surveyor did and it raised the surveyor up above the top of the fence. The distance the resident traveled could vary from .15-.25 miles depending on if he cut across the yard, went through grass and went between buildings. It took the surveyor approximately 5 minutes to travel the distance with continuous walking minus any stops or looking around. Abatement: The facility abated the immediate jeopardy on 6/2/20 when they educated staff and developed the policy that identified staff would ensure constant supervision of residents in the secured courtyard and staff would not prop doors open leading to the secure courtyard. The facility was notified of the immediate jeopardy on 6/11/20.