STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165146	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KAHL HOME FOR THE AGED & INFIRMED	**6701 JERSEY RIDGE ROAD DAVENPORT, IA 52807**

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, staff interview and record review the facility failed to provide adequate supervision for 1 of 3 residents reviewed and resulted in an elopement from the facility (Resident #1). The facility identified a census of 91 residents. Findings include: 1. A Minimum Data Set (MDS) Assessment for Resident #1, dated 6/4/20, showed the resident with [DIAGNOSES REDACTED]. The resident had a Brief Interview of Mental Status (BIMS) of 5 indicated the resident with severe cognitive impairment. The resident required supervision with transfers, ambulation, bed mobility, dressing and toilet use. The MDS did not indicate the presence of wandering or the use of an assistive device for the resident. A Care Plan for Resident #1, dated 9/9/19 showed the resident as an elopement risk/wanderer related to disorientation to place, impaired safety awareness, and behavior of wandering aimlessly. Interventions on the Care Plan dated 9/9/19 were to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and book. Also an intervention to identify a pattern of wandering and intervene as appropriate. Another intervention included provide structured activities such as toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Review of the Nurse Progress Note dated 12/5/19 at 2:25 a.m. showed a staff member found the resident walking down the stair way. The resident located on a different floor in the facility with their coat on. The staff were able to redirect the resident back to their room. The facility did not provide an incident report for this date. An intervention added to the Care Plan for the resident, dated 12/9/19, for placement of a wander guard on the resident's ankle. The intervention included the resident frequently removed the wander guard bracelet. A Progress Note dated 12/11/19 at 1:13 p.m., documented the resident changed rooms due to wandering behavior and resident safety. Review of the Order Summary Report showed orders, dated 1/5/20 to check the wander guard function every Friday morning and to check the placement of the wander guard every shift. The Care Plan showed an intervention, dated 7/4/20, of a one to one sitter provided on the 2 p.m.-10 p.m. shift and the 10 p.m.-6 a.m. shift, urine dip, and lab evaluation. A Progress note dated 7/4/20 at 3:12 a.m. showed Staff A, Licensed Practical Nurse (LPN), informed at 1:14 a.m. by staff the door alarm sounded and the resident could not be located in the stair way or their room. The resident was brought back to the facility at 1:55 a.m. after found sitting on a bench at a car dealership. The Wandering/Elopement Assessment, dated 9/3/19 showed the resident at moderate risk for wandering and the resident had a history of [REDACTED]. The Wandering/Elopement Assessments, dated 12/1/19, 3/1/20, and 5/31/20 showed the resident at moderate risk for wandering. The Wandering/Elopement Assessment, dated 7/9/20, revealed the resident at moderate risk for wandering. The assessment also showed the resident wandered on the unit to exit seek despite staff attempts to redirect. The wander guard in place but the resident often removed. The facility investigation included: The Occurrence Report, dated 7/4/20 at 4:37 a.m. completed by Staff A, LPN, revealed on 7/4/20 at 1:14 a.m. she received a call from a Certified Nurse Assistant (CNA), while caring for another resident the door alarm to the Dementia Unit had sounded. The CNA checked the stairway and the resident rooms and were unable to locate Resident #1. Two facility staff found the resident sitting on a bench at a car dealership at 1:55 a.m. The resident was brought back to the facility by the staff members. Staff completed a body check and there were no injuries identified. The resident's knees were slightly red but blanchable, the resident did not have complaints of pain or discomfort and range of motion within normal limits. A Per MAR indicated [REDACTED]. The Incident Report showed Staff B, CNA, heard the door alarm sound on the Dementia Unit while Staff B attended to another resident. The staff were unable to locate the resident. At 1:16 a.m. the Security Staff saw on the camera the resident walked out the south stairwell door and down to the parking lot on the backside of the facility. At approximately 1:55 a.m. Staff C, Certified Medication Tech, and Staff D, Registered Nurse (RN), found the resident sitting on a bench at a car dealership approximately 1/2 to 1 mile east of the facility at the corner of 2 four lane streets. At 2:01 a.m. Staff C and Staff D brought the resident back to the facility by car. The Follow Up Report, dated 7/6/20, completed by the Administrator, revealed the facility completed a urinalysis and lab work for the resident. The facility incorporated a sitter with the resident from 2 p.m. until 6 a.m. each day. The root cause of the incident determined as due to resident action or internal risk factors. An observation of the resident on 7/9/20 at 2:06 p.m. showed the resident sat on the side of the bed. The resident had a wander guard bracelet secured to the right ankle. Observed the resident on 7/13/20 at 1:45 p.m. showed the resident rested in bed. An observation on 7/13/20 at 2:08 p.m. showed the resident sat on the edge of the bed with a sitter located in the room with the resident. A demonstration of how the resident exited the facility conducted on 7/9/20 at 2:35 p.m. by the Administrator and Staff E, LPN, Unit Manager, showed the resident exited the stairwell 4 exit door on the Dementia Unit. The resident traveled down the stairs and left the building through the first floor exit door on the backside of the facility. The resident walked down a hill to the back parking lot and followed the parking lot to 4 lane road and turned left. The resident crossed the 4 lane road with a speed limit of 45 miles per hour. Facility staff found the resident sat on a bench in front of a car dealership located approximately 0.6 miles from the facility as per The state Climatologist reported in Davenport on 7/4/20 at 2:00 a.m. a temperature of 67 degrees and 87 percent humidity. Review of the Facility Staff Schedule, dated 7/3/20, showed one CNA on the Dementia Unit and one nurse for the two units on the floor of the facility. During an interview on 7/9/20 at 12:35 p.m., the Administrator reported on the night of the incident the CNA on the Dementia Unit heard the door alarm go off so the CNA checked the front exit door and did not see anything then realized the alarm came from the back exit door. She reported the CNA went down the back stairwell and after a room check the staff identified the missing resident to be Resident #1. The Administrator reported the facility conducted a perimeter search and could not locate the resident. The Administrator reported she had been contacted approximately 30 minutes after the incident and instructed the staff to contact the police. She explained that the facility staff were able to locate the resident at a car dealership down the road and the staff brought the resident back to the facility. The Administrator reported the facility implemented a sitter with the resident from 2 p.m. until 6 a.m. An interview on 7/9/20 at 1:21 p.m. the Plant Operations Director explained the first floor exit doors require a badge swipe to enter the facility. He reported the first floor exit doors did not alarm when the doors open to exit the facility. An interview on 7/13/20 at 11:15 a.m. Staff F, Scheduler, reported the usual staffing pattern for the facility on the night shift is one nurse per floor and two CNA per unit. An interview on 7/13/20 at 11:45 a.m. Staff F, reported the night of the incident a staff member notified the facility they would be late to work. She reported one of the two CNA's scheduled on the Dementia Unit had moved to another unit and left one CNA on the Dementia Unit. An interview on 7/13/20 at 12:04 p.m. Staff B, CNA, reported the night of the incident the resident wanted to go downstairs to meet their daughter. Staff B reported she sat and talked with the resident and explained it was late and the resident's daughter was asleep. Staff B reported the resident decided to go into their room so she waited to ensure the resident would not come back out of their room before she started the unit rounds. She reported the resident declined to

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) take their jacket and shoes off when they returned to their room. Staff B could not recall who the other staff were that were scheduled to work on the Dementia Unit with her that night. She explained the normal staffing for the night shift is one nurse for the floor and 2 CNA for the unit. Staff B reported while providing care to another resident on the unit she heard the door alarm sound. She reported she exited the resident's room and went to the front exit door of the unit but realized the alarm sounded at a different exit. She reported she sprinted to the back exit as it went to an outside exit door. She reported she went down two or three stairs and did not hear or see anyone. Staff B remarked the last time she observed the resident approximately 40 to 45 minutes prior to the incident. Staff B reported she placed a call to Staff D, RN and Staff A, LPN and they came to the unit. Staff B explained a search of the unit along with the facility conducted. She reported staff were able to find the resident down the street at a car dealership. She reported the resident returned to the facility and had no injury. During an interview on 7/13/20 at 1:58 p.m. Staff G, CNA, reported the resident moved up to the front of the Dementia Unit after the first elopement attempt. She reported the resident's first attempt to elope happened during the night as well. During an interview on 7/13/20 at 2:28 p.m. Staff H, CNA, explained a staff from the agency hired to sit with the resident had reported the resident talked of plotting it again. Staff H could not recall if she reported the conversation to anyone at the facility. During an interview on 7/14/20 at 5:43 a.m. Staff I, Per MAR indicated [REDACTED]. Staff I reported she had not seen a resident on the floor and continued to watch the video camera. Staff I explained when a stairwell door alarm sounds she is not able to hear it at the reception desk on the first floor. Staff I remarked facility staff thought the resident may have gone outside so she went back and reviewed the video footage and found the resident exited the facility at 1:16 a.m. Staff I reported she did not see the resident leave the building on the camera at the time the incident occurred. Staff I explained the Police arrived to the facility at 2:01 a.m. just prior to the staff and the resident. An interview on 7/14/20 at 6:15 a.m. Staff J, RN, reported she observed a previous incident when the resident looked around the corner and then the resident ran to the bathroom at the front of the Dementia Unit near the dining room. She reported the resident leaned on the door to keep the staff from going into the bathroom. She reported the incident happened more than one time and a staff member had to sit outside of the resident room. An interview with the Director of Nursing (DON), RN, on 7/14/20 at 7:10 a.m. reported the resident had previously left home and the reason the resident had been placed in the facility. She explained the resident previously had been a runner and is fast. She reported the resident had a wander guard placed shortly after admission and the resident had a history of [REDACTED]. The DON reported no knowledge of resident attempt to leave the facility prior to the night of the incident. The DON explained the expectation for the night shift staffing in the facility is to have 1 nurse cover two units and 2 CNA cover each unit. During an interview on 7/14/20 at 8:34 a.m. Staff D, RN reported she received a call from Staff B who explained they thought one of the resident's had left the floor. Staff D reported she went up the stairs and started searching the stairwells. She reported Staff B, CNA completed a search of the resident rooms on the floor. Staff D explained the other staff in the facility checked the other floors for the resident. When the resident could not be found in the facility Staff D remarked she searched outside of the facility. She explained another staff member and herself drove through the dealership parking lot and when they drove out of the parking lot they observed the resident sat on a bench. Staff D reported she checked the resident over and the staff brought the resident back to the facility in the car. Staff D explained the night of the incident the Dementia Unit only had one CNA. She reported the Supervisor is in charge and determined the staff work assignment when the facility had a call off. An interview on 7/14/20 at 9:52 a.m. the Administrator reported the Dementia Unit had the capability to house 23 residents. She explained the night of the incident the census on the Dementia Unit had been 21 residents. She remarked the resident had left home and is the reason the facility placed a wander guard on the resident. The Administrator reported no awareness of the resident ever found in the facility stair well. The Administrator explained the staffing pattern in the facility is based on the facility size. She remarked the night shift staffing is 1 nurse per floor and 2 CNA per unit. She reported if there had been a call off one CNA will overlap between units. The Administrator confirmed the night of the incident the Dementia Unit had been staffed with one CNA. During an interview on 7/14/20 at 10:36 a.m. Staff A, LPN reported Staff B, CNA had called her due to the door alarm sounding and a possible missing resident. She reported at the time of the call she had another incident she needed to attend to and could not leave to go to the Dementia Unit. Staff A remarked it took her approximately 10 to 15 minutes to respond to the dementia unit. She explained when she arrived to the unit Staff B completed a room check as they were the only staff member on the dementia unit and could not leave. She explained other facility staff searched the rest of the facility. She explained Staff D and Staff C found the resident at a car dealership up the road. When the staff brought the resident back to the facility Staff A explained she completed a body check and the resident had no injuries. She remarked the resident's knees were slightly red but blanchable. She reported the redness subsided within 20 minutes. Staff A explained the resident had reported they ducked down when cars passed by. Staff A reported the facility tried to put 2 CNA on each unit but due to a call off that evening the staffing ended up with one CNA on the dementia unit. She explained when the facility had call off the supervisor made changes to staff assignments and on the night of the incident she had been the supervisor. Staff A reported she could have probably done something different related to the staff assignments the night of the incident. An interview on 7/14/20 at 10:59 a.m. the Administrator reported the facility does not have a policy for facility staffing. During an interview on 7/15/20 at 8:45 a.m. the Administrator reported she looked into the incident and the Nurse Supervisor made an error in judgement. She explained Staff A should have looked at the acuity of the resident's when she determined the staff assignments for the night of the incident. Review of the Facility Assessment, updated October 28, 2019, showed the ratio for night shift CNA's as 1:10. Review of the Elopement Prevention Policy, revised 2/1/4, revealed the policy is to identify residents who have a high risk for elopement, to put interventions into place to prevent elopement of residents and to ensure that the facility's specific interventions are effective. Additionally the policy provided for a system by which the Interdisciplinary Care Plan Team would be alerted to the resident's potential for wandering and elopement. The Risk Assessment Procedure portion of the policy showed: 9. Any staff member observing a confused resident or previously identified wandering resident attempting to leave the premises shall intervene to prevent departure. Should the intervention fail, the staff member shall obtain assistance of other staff members in the immediate vicinity. The Risk Assessment Procedure also noted the staff member should remain with the resident if the resident's safety is in question. Review of the Door Alarm Check Policy, revised 6/24/17, showed all door alarms are checked every third week by Maintenance Supervisor. A 24 hour a day monitored Infinias System by front desk personnel. The procedure section of the policy revealed doors are monitored 24 hours a day at front desk reception through the Infinias door lock system. The incident detailed above resulted in determination of Immediate Jeopardy for the facility and notified of such on 7/14/20 at 3:45 p.m The Facility Staff abated the Immediate Jeopardy situation on 7/14/20 through the following actions: a. All staff in-serviced beginning 7/14/20 to include the operating instructions to the new (temporary) alarm system on the four doors leading to the stairwell. b Also the Nursing Supervisors in-serviced on the staffing policy and 24 hour 1-1 (uninterrupted) supervision of a resident/s as required to ensure safety. The call light will be signaled and answered before a sitter can be dismissed for any reason. c. A temporary alarm system on the four doors leading to the stairwells on 7/14/20 with a follow-up by the alarm company to install a permanent door alarm system on 7//15/20. After installation, staff will receive in-service training on the new system as well. Based on the results of the corrective measures taken by the facility lowered the scope and severity of the deficiency from a J level to a D level.