STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165515	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNNYCREST NURSING CENTER	**401 CRISMAN STREET DYSART, IA 52224**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to ensure door alarms were properly activated resulting in 1 of 3 residents (Resident #1) eloping from the facility. The facility reported a census of 38 residents. Findings included: Resident #1's 6/5/20 Minimum Data Set (MDS) documented the resident with [DIAGNOSES REDACTED]. He had a Brief Interview for Mental Status (BIMS) of 3 indicating severely impaired cognition. The resident's Care Plan dated 8/11/20 indicated the resident is an elopement risk/wanderer related to disorientation to place and resident wanders aimlessly with a goal that the resident will not leave the facility unattended through the review date. The Care Plan further revealed Resident #1 had a wander alert in place. Review of Resident #1's Nurse's Notes dated 8/17/20 revealed the following: a. At 1:37 p.m., Staff B, Licensed Practical Nurse (LPN) documented resident attempted to exit the facility 3 times during the shift. Resident was calm, confused, easily redirected and a wander guard was in place on his right arm. b. At 3:30 p.m., Staff B documented resident continued wandering and confusion was reported to the Advanced Registered Nurse Practitioner (ARNP) and an order for [REDACTED]. d. At 6:15 p.m., Staff C, LPN documented resident wandered out of the facility via the north exit door. Alarm was sounding and aides were able to easily redirect resident to his room. Resident stated he lived in Cedar Rapids and was looking for his son who was giving him a ride. e. At 6:45 p.m., Staff C documented a neighbor of the facility was at the front door stating that one of the residents was outside with his pants down. Resident #1 was walking along the sidewalk in front of building and was easily redirected back into the building. Resident stated once again he was looking for his son to give him a ride to his home. Resident went to bed and Staff C assigned a Certified Nursing Assistant (CNA) to stay with resident one on one. Upon inspection of the north door the alarm had not been reset properly from the previous elopement some 20 minutes prior. f. At 9:02 p.m., Staff C texted the DON and let her know the situation and was instructed to move Resident #1 to a room in the south hall. The CNA's requested to leave resident as he had just fallen asleep and were afraid that moving him would awaken him. Staff C agreed and placed him on 15 minute checks with instructions to be vigilant in regards to checking every 15 minutes. Staff C checked the door to ensure alarms were armed. Review of Resident #1's Nurse's Notes dated 8/18/20 revealed the following: a. At 10:31 a.m., Staff B, LPN documented resident had been asleep since 6:30 a.m. after a night of [MEDICAL CONDITION] and wandering as reported per night shift. Will allow resident to rest at this time instead of waking for medication administration. DON aware. b. At 11:10 a.m., Staff B documented new order received from ARNP for [MEDICATION NAME] (an antibiotic) 100 milligrams 2 times a day for 7 days for a urinary tract infection [MEDICAL CONDITION]. c. At 12:28 p.m., Staff D, Registered Nurse (RN) documented spoke with Resident #1's family member in regards to the Resident #1's exit seeking behavior and eloping from the building last evening. Staff D informed the family member that the facility Social Worker would be looking for other placement for the resident that has a locked memory care unit. The family member verbalized understanding. d. At 1:03 p.m., the DON documented a physical assessment status [REDACTED].#1 including a skin assessment with no new areas of concern noted to skin. Resident denied pain. e. At 3:32 p.m., Staff D documented spoke to Resident #1's family member and was given permission for the resident to be transferred to sister facility where a locked unit had a bed available. Staff D informed the family member the transfer would most likely happen tomorrow. Review of documentation in the Nurse's Notes dated 8/21/20 at 8:30 AM by the DON revealed Resident #1 left the facility via taxi with a CNA to be transferred to the other facility. In an interview on 8/20/20 at 10:36 a.m., Staff F, CNA stated she provided one to one care for Resident #1 from approximately 7:00 p.m. until 9:00 p.m. on 8/17/20. During that time the Resident #1 was up and down a lot. Staff F reported she tried to toilet him on two different occasions but he was still up and down a lot during that time and was very anxious. At approximately 9:00 p.m., Resident #1 was snoring so the one to one care ended with plan to check on Resident #1 every 15 to 20 minutes until the shift ended at 10:00 p.m Staff F reported passing on to 3rd shift staff that Resident #1 had been up and down a lot and suggested checking on him frequently through the night as unsure if he would be getting back up. Staff F stated she was vaguely familiar with Resident #1. Stated Resident #1 was in the locked unit at the previous facility he was evacuated from due to storm damage and Staff F had only worked 3 shifts during the 2 months she had been employed at that facility. To the best of Staff F's knowledge Resident #1 was a wanderer but his behavior was unusual on 8/17/20. In an interview 8/20/20 at 12:15 p.m., the Administrator and DON reported in room [ROOM NUMBER] a resident had fallen occupying the nurse's and CNA's attention. Resident #1 was in room [ROOM NUMBER] at the end of the hall and the exit door was next to his room. The doors had double alarms which included a sensor alarm and a key pad alarm. The key pad alarm had been toggled to the off position when the 6:15 p.m. event occurred and it had not been toggled back to the on position. The DON was unsure if the motion sensor alarm was on or not. A facility investigation was conducted and none of the staff members that worked the evening of 8/17/20 claimed they turned off the alarm or knew who did. Resident #1 currently resides in room [ROOM NUMBER] in the south hall. The room is located in the middle of the hallway and is not by an exit door. The key pad alarms toggle switches were removed from the key pad alarms on 8/18/20 so they are no longer able to be deactivated. The motion sensor alarms were moved 18 inches from the exit doors into the hallway to act as a pre-alarm. The Administrator and DON reported nothing was eventful on 8/17/20 until the evening. Reported Resident #1 had come out of his room during the day but was not exit seeking and would return to his room. At 6:15 p.m., Resident #1 went out the north door. A Certified Medication Aide (CMA) was outside and heard the alarm from the outside and went around to where the alarm was coming from and saw Resident #1 going down the sidewalk. At 6:45 p.m., another resident had fallen occupying a CNA and Staff C. The Administrator and DON reported Resident #1 went out the door at that time and a community member saw Resident #1 outside and came to the front door to report. Staff C, LPN brought Resident #1 back inside. The Administrator and DON reported Resident #1 had been restless when back in his room. A CNA stayed in the room with him until Resident #1 fell asleep. The DON was notified and the plan was to have Resident #1 move to a private room closer to the Nurse's Station. The DON stated Resident #1 slept all night until lunch the next day, ate lunch and then was moved to the different room. Resident #1 was started on an antibiotic on 8/18/20 for a UTI. Reported historically the UTI caused agitation for Resident #1. Stated Resident #1's family member lives in an apartment complex across the lawn from Resident #1's previous nursing home and when Resident #1 looks out the window he doesn't see that building so that is why he is looking for his family member. At the previous facility, Resident #1 regularly received window visits from his family member so he is physically looking for his family member as well. In an interview on 8/20/20 at 12:41 p.m., Staff E, CNA revealed the night of Resident #1's elopement on 8/17/20 she and another CNA were in another resident's room and needed supplies from the hall closet. Staff E went to the hall closet when she heard an alarm going off around 6:15 p.m. Staff E stated she ran to the front door and realized it wasn't the front door alarm so she went to the north door. While walking out the north door she saw the resident walking with the CMA that had been outside on break walking to the front door.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165515	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNNYCREST NURSING CENTER	**401 CRISMAN STREET DYSART, IA 52224**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Staff E reported she then met Resident #1 and the CMA at the front door. Staff E denied being the one that turned off the door alarm and stated another CNA, she couldn't remember who, came to shut off the alarm because Staff E wasn't sure how to shut it off as it is different than the one in the kitchen that she usually shuts off. Staff E denied additional information related to the 6:45 p.m. incident as she was working the other side. In an interview on 8/20/20 at 2:35 p.m., Staff J, stated she was outside on a break at 6:15 p.m. when she went to the front door to ring the bell to be let back in. Stated through the door she saw 3 CNA's running to the north wing and she heard the alarm going off. Reported she went around to the north door and saw Resident #1 in the parking area and a pedestrian was approaching him. Staff J reported she went to the Resident #1 and assisted him back into the building and that by the time she returned to the building the alarm was no longer sounding. Staff J reported she is not sure who shut off the alarm. Stated she was working another wing so was not there for the 6:45 p.m. event. In an interview on 8/24/20 at 3:45 p.m., Staff G, CNA revealed she went to get briefs for a resident that was on the toilet around 6:15 p.m. on 8/17/20. Stated heard an alarm and knew two other aides were down that hall. Reported she saw a Certified Medication Aide (CMA) from agency bring Resident #1 back inside the front door but didn't know the CMA's name. Staff G denied knowing who turned off the alarm to the north door. In an interview on 8/25/20 at 9:00 a.m., Staff C, LPN reported he heard the alarm go off around 6:45 p.m. at the front of the building and a neighbor was at the door and let him know a resident was outside. Staff C went out and got Resident #1, brought him back into the building, did a quick head to toe assessment, no concerns noted and initiated one to one care. Stated the girls didn't know how to reactivate the alarm on the north door after Resident #1 went out around 6:15 p.m Staff C stated agency staff were working the north hall the evening of 8/17/20 and along with Staff F, CNA provided one to one care after Resident #1 exited the building around 6:45 p.m. Staff C stated the next day maintenance removed the toggle from the alarms on the doors. Prior to the toggle being removed, the alarm could be de-armed by using the off switch. Now with the toggles removed, the alarm will sound until the code is entered and once the code is entered it will automatically reset. In an interview on 8/25/20 at 10:30 a.m., Staff I, CNA Agency Staff revealed she had been told the code on the key pad alarm and how to turn it back on. Now all the alarms stay on after they are reset except the alarm by the dumpster which you make sure is turned back on. In an interview on 8/25/20 at 10:40 a.m., Staff K, Agency Staff reported she worked at this facility for about 3 weeks. Stated she had been re-educated on the alarms by the Administrator after Resident #1 exited the facility. In an interview on 8/25/20 at 10:50 a.m., Staff L, Agency Staff stated she had been coming to this facility for 4 or 5 months. Stated she was educated on how to use the alarms when she first started working at the facility and then again about 1 month later and that staff can always ask someone if the don't know how to use them. Reported she has reset the alarms in the past and the sensor alarms are very sensitive and anytime someone gets near them they are activated which is good for the residents. In an interview on 8/25/20 at 12:33 p.m., Staff H, CNA reported she didn't know which door Resident #1 went out around 6:45 p.m. on 8/17/20 as she was assisting a resident with dining in the dining room. Reported she did not touch the alarms. Stated she had been told the codes but she doesn't know how to operate the coded alarm on the doors and she didn't recall being trained. Stated it has been 6 months to a year that she had worked at this facility prior to 8/17/20 and she hasn't been back to the facility since.