STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	09/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072 Based on record review, staff and family interview the facility failed to notify the family member/responsible party of a change in resident condition for 2 out of 3 residents reviewed (Residents # 1 and #4). The facility reported a census of 50 residents. Findings include: 1.) According to the Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 shown diagnoses include Non Alzheimer's Dementia and anxiety disorder. The MDS indicated Resident #1 scored a 4 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident severe cognitive impairment. The assessment revealed the resident had wandering behaviors daily. The MDS indicated the resident needed supervision and one assist of staff with transfers and ambulation. Review of the nurse progress notes from 8/7/21 at 2:06 p.m. reveal Resident #1 went out the door and was found at the end of the block in the middle of the street. The care plan with revision date of 6/9/21 states Resident #1 is at high risk for falls. The interventions direct staff to involve resident and/or responsible party in treatment plan. Update as needed regarding change in condition/treatment. Review of the nurse progress notes for the month of August 2021 failed to document any notification to the family or power of attorney for Resident #1 of incident on 8/7/21. During an interview on 9/1/21 at 11:55 a.m. with son he states he was not aware of Resident #1 elopement until yesterday when the facility called to notify him. They also did not tell him had occurred on 8/7/21 made it sound like it had just happened yesterday. During an interview on on 9/2/21 with Staff A, Licensed Practical Nurse states staff should have notified the family and physician of elopement. It would be documented if they notified family. 2.)According to the Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 shown diagnoses include Anemia, Renal Insufficiency and Hip Fracture. The MDS indicated Resident #1 had no short or long term memory problems and was independent with decision making. The MDS indicated the resident needed limited to extensive physical assist with transfers, ambulation and personal hygiene. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's telephone order dated 8/10/21 at 1:35 p.m. revealed a physician order for transfer to emergency room due to rectal bleeding with pain, low blood pressure for rectal exam and further evaluation. The nurse progress notes 8/10/21 at 2:15 p.m. reveal Resident #4 was transferred to emergency room with orders, face sheet and current vital sign information. Review of the progress notes failed to reveal any documentation of family/responsible party notified of transfer to emergency department. During an interview on 9/2/21 with Staff A, LPN states she failed to notify Resident #4 family of transfer to emergency room . I was busy and forgot to notify family, when the hospital called at 6:00 p.m. they stated family was with the resident so I knew they were aware by then she was at hospital. During an interview on 9/8/21 at 1:20 p.m. with the Director of Nursing (DON) states she would expect staff to notify family if there is a change of condition, elopement, medication changes or if sent to the hospital staff should immediately call the family. The facility provided a policy titled Notification of a Change in a Resident's Condition dated 11/1/18 which directs staff of guideline for notification of Physician/Resident Representative: significant change of unstable vital signs, any accident or incident (per Federal and State regulations) and missing resident.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 37072 Based on observation, record review, and staff interview the facility failed to provide adequate supervision for 1 of 4 sampled (Resident #1) for elopement. On 8/7/21 at 2:00 p.m., Resident #1 who had cognitive impairment eloped from the facility without staff knowledge. The staff reported the alarms failed to sound. The facility failed to fully repair a door alarm known to not function prior to the elopement. The facility failed to thoroughly investigate the root cause of the elopement. The failures resulted in Immediate Jeopardy to the health, safety, and security of the residents. The facility reported 5 resident had cognitive impairments and independently mobile. The facility reported a census of 50 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 had diagnoses of anxiety and dementia and had Brief Interview for Mental Status score of 4, indicating severe cognitive impairments. Resident #1 required supervision of one with staff with transfers. The Care Plan dated 4/14/21 revealed Resident #1 had a memory problem, impaired decision making, problems understanding others, and disorganized speech. The Care Plan documented Resident #1 had a history of a fall with a right arm fracture and visual impairments due to glaucoma. The Elopement-Wander Risk Scale dated 6/9/21 revealed Resident #1 had a low risk for elopement. The Weekly Door Alarm Inspections Error Log sheet dated 2021 documented on 8/6/21 locks not working. The Progress Notes dated 8/7/21 at 2:06 p.m., documented Resident #1 exited the front door and found to in the middle of the road at the end of the city block. The staff assisted Resident #2 back inside with her walker and placed a wanderguard bracelet on her. The staff notified the Director of Nurses by phone. During an interview on 8/31/21 at 10:00 a.m., Staff C (Licensed Practical Nurse) stated she was outside on break when an Assisted Living employee assisted Resident #1 to the back entrance of the facility with her walker. The Assisted Living Staff informed Staff C she found Resident #1 at the end of block in the middle of the street. Staff C figured Resident #1 exited the [NAME] door. Resident #1 stated she was trying to find her family. Staff C thought she observed Resident #1 inside the facility before exiting the facility for her break 10 minutes earlier. Staff C assessed Resident #1 and found no injuries, notified the Director of Nurses, and applied a wanderguard bracelet. Staff C reported the [NAME] door alarms were malfunctioning at the time. When the door opened it only set off the whistle not the buzzer. When opening the door from the outside to return inside there was no whistle or buzzer. At the time Resident #1 went outside there was nothing going off for alarms. There was no alarm sounding when Staff C entered the facility. They are in the process of fixing everything now. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 8/31/21 at 2:00 p.m., Staff E (Certified Nurse Aide) stated she was not sure when she last saw Resident #1 prior to the elopement. Staff E assumed Resident #1 exited the front door and reported the front door alarm was not working. The front door alarm sounded for no reason. During an interview on 8/31/21 at 2:20 p.m., Staff D (Certified Nurse Aide) stated she didn't recall hearing an alarm when Resident #1 eloped. Staff D answered another resident's call light and someone informed her Resident #1 eloped. Staff D reported something was going on with the front door alarm. Staff D did not know how long the alarms had malfunctioned. Staff D reported Resident #1 wandered the facility and required redirection to get back to her room. During an interview on 8/31/21 at 2:55 p.m., the Director of Nursing (DON) stated she worked the day Resident #1 eloped. The DON reported electrical problems and the alarm. The alarms sounded and the staff reset them and then they would sound again for not reason. The DON directed the staff to notify maintenance of the issue. The DON received a call on her way home informing her Resident #1 had eloped. The DON directed the staff to place a wanderguard bracelet on Resident #1. The DON worked again the following Monday, Tuesday, and half day on Wednesday and did not remember to do anything about it. The DON reported the nursing staff check the resident's bracelets for function but do not check the door alarms for function. However, due to the trouble with the alarms they are now checking the wandergaurd alarms on the doors. The DON did not know when the checks started as she was on vacation. During an observation on 8/31/21 at 8:43 a.m., revealed front door alarm going off and no resident at the door. Staff F (Laundry Aide) responded and shut alarm off and moved away from door. The alarm sounded again and Staff F walked away from the alarming door. An unidentified staff reset the alarm. During an interview on 8/31/21 at 11:25 a.m., the Maintenance Director explained the magnets for the fire doors were not working but the alarms were working. The staff just ignored it or didn't hear it. Someone must have silenced it. During an interview on 8/31/21 at 3:30 p.m., the Maintenance Director reported the staff called him in after dinner the evening of the elopement to ensure the door alarms functioned. The Maintenance Director found no issues with the door alarms. The Maintenance Director thought it was possible the switch got turned off but it was on when he arrived. He added a small battery operated alarm to the front door, north, east and west fire exit doors on 8/16/21 due to issues. The front door didn't lock but it did alarm and not sure why staff say it was not functioning. On 8/16/21 the Administrator had the Maintenance Director implement a log for checking all the door alarms due to the staff reports of it not functioning. The Maintenance Directed stopped the logs on 8/23/21. During an interview on 9/2/21 at 9:40 a.m., Staff A (Licensed Practical Nurse) stated recalled observing Resident #1 in the day area and then on the west wing 10 to 15 minutes prior to the elopement. The Assisted Living staff assisted Resident #1 back inside and reported they found Resident #1 in the road. Staff A reported she did not recall hearing any door alarms sounding. The Maintenance Director reported the door alarms were not functioning properly and to keep an eye on the residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation 9/8/21 at 12:45 p.m. revealed a posted speed limit of 25 miles per hour on the street where the staff found Resident #1 unattended. The facility had a large apartment complex across the street. During the observation 2 to 3 cars traveled east and west every minute. Uneven surfaces noted on the cement at end of driveway and the curb. During an interview with the State Climatologist on 9/8/21 at 12:28 p.m., revealed a temperature of 86 degrees Fahrenheit (F), relative humidity 66%, heat index 93 to 97 degrees F, winds out of the south at 13 miles per hour, skies clear and visibility of 10 miles on August 7, 2021 at 2:06 p.m. During an interview on 9/13/21 at 1:00 p.m., the Administrator reported an expectation of staff to notify the Director of Nurses or Administrator immediately following an elopement, and notify the police, the physician, notify the family, and conduct an assessment. Then the administrative staff conduct a root cause analysis to determine the cause of the elopement. The Administrator reported the staff should have implemented a plan to ensure the alarms were functioning at the time of the elopement. An email from an Alarm System dated 9/1/21 revealed a Technician made a visit on 8/17/21 and determined a fire panel without DC voltage and ordered a new power supply. On 8/23/21, a Technician back onsite with new power supply and installed. The contractor troubleshooted in the attic and agreed with the Maintenance Director that it might be cheaper and better to have an electrician troubleshoot circuiting. The wandergaurd doors operated when the Technician departed. The Maintenance Director verbalized a plan to have an electrician look into the corridor doors and let him know. The Contractor never heard back from either. The State Agency informed the facility of the Immediate Jeopardy on September 1, 2021 at 8:55 a.m. The Facility removed the Immediate Jeopardy on September 1, 2021 by implementing the following actions: a. Conducting Elopement Risk assessments on all residents and ensured interventions in place. b. Staff education for monitoring residents at risk for elopement, elopement policy including notification to Administrator, Director of Nurses, and Police, and ensuring door alarms are functioning. c. Ensuring newly hired staff receive education on hire. The scope lowered from K to E at the time of the survey after ensuring the facility implemented education and their policy and procedure.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 37072 Based on observation, record review and staff interview, the facility failed to ensure the daily staffing data was posted on a daily basis in a prominent placereadily accessible for residents and visitors for 4 of 6 days of the survey. This had the potential to affect all residents in the facility. The facility reported a census of 50 residents. Findings include: 1. On 8/30/21 at 3:32 p.m. observed the daily staffing sheet posted on the bulletin board outside the administrators office at the front entrance dated 8/27/21. 2. On 9/1/21 at 2:00 p.m. observed the daily staff sheet posted on the bulletin board dated 8/31/21. 3. On 9/2/21 at 10:50 a.m. observed the daily staff sheet posted on the bulletin board dated 8/31/21. 4. On 9/8/21 at 9:45 a.m. through 12:35 p.m. observed no daily staff sheet posted on the bulletin board. During an interview on 9/8/21 with the Marketing and Admission Director states she is responsible for posting nurse staffing. It should be posted daily. It may not have been up due to taken down to be corrected. During an interview on 9/8/21 at 1:20 p.m. with the Director of Nursing the nurse staffing sheet should be posted every day. During an interview on 9/8/21 at 2:15 p.m. the interim Administrator stated he would expect staff to follow the regulation for posting nurse staff information.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072 Based on observation, record review and staff interview the facility failed to accurately document the use of wander guard for 1 out of 3 residents reviewed (Resident #3). The facility revealed a census of 50 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 shown diagnoses include Alzheimer's Dementia and depression. The MDS indicated Resident #2 had short and long term memory problem and difficulty with decision making in new situations. The assessment revealed the resident had wandering behaviors daily. The MDS indicated the resident independent with no set up or physical help from staff with transfers and ambulation. Review of Resident # 2 Care Plan initiated 3/22/21 revealed an elopement risk/wanderer and interventions directed staff to wanderguard alert bracelet on left wrist. Check placement and function each shift. The wandering risk scale dated 6/16/21 revealed a score of 11 indicates above high risk to wander. The progress note dated 8/13/21 revealed Resident #2 stated he was leaving and walked out the front door. He had took his wand guard off. Social services director followed him out to try and redirect. During a observation on 8/30/21 at 5:07 p.m., Resident #2 is sitting at the dining room table eating and no wanderguard on both upper extremities. During an observation and interview on 8/30/21 at 5:30 p.m., Staff B (Certified Nurse Aide) verified Resident #3 did not have a a wanderguard device. During an observation on 8/31/21 at 7:50 a.m., Resident #2 sitting at table in the main dining room without a wanderguard device. During an observation on 8/31/21 1:15 p.m., Resident #2 independently ambulating to room showed his arms and legs without a wanderguard in place. During an observation on 9/1/21 9:00 a.m., Resident #2 sitting in recliner chair in main lounge area without a wanderguard device. During an observation on 9/1/21 2:00 p.m., Resident #2 in room without a wanderguard device. Review of the Treatment Administration Record reveal wanderguard on per nursing judgement, check every shift three times a day related Dementia. Check every shift per nursing judgement. The record is signed out for 8/30/21 for 12p-3 and 4p-7p. The record is signed off for 8/31/21 7a-11 and 12p-3. The record is signed off for 9/1/21 for 12p-3 and 4p-7p. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/21 at 5:35 p.m., Staff C (Licensed Practical Nurse) stated the wanderguard should be on his wrist or ankle. It is per nursing judgement and if he is at risk should have a wanderguard on his arm or leg. If they have a wanderguard we check the actual function of it every shift. During an interview on 8/30/21 at 5:50 p.m., Director of Nursing (DON) stated if the treatment sheet states they have a wanderguard on and if the treatment administration record is signed out it means the staff checked it. If the care plan states they have a wanderguard on they should have one in place. During an interview on 9/8/21 at 2:15 p.m., the Administrator reported the facility lacked a policy for documentation and they follow the regulations.