

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER Southeast Iowa Regional Medical - Klein Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 South Gear Avenue West Burlington, IA 52655	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506</p> <p>Based on observation, clinical record review, facility incident and investigation reports, and staff interviews, the facility failed to ensure a resident with a severe cognitive impairment did not exit the facility without staff knowledge. On 7/26/24, Resident #1 left a group while walking from an activity area to the memory care unit unbeknownst to the staff supervising. Resident #1 walked through the front lobby and exited out an unlocked, unalarmed door to an unsecured courtyard area. The resident walked on the sidewalk to the area between the B and C wings of the building, a location approximately 100 yards from a large pond. A staff member saw the resident from a window, and went outside to assist her back to the building. Resident #1 estimated to be outside, unsupervised for approximately ten minutes for 1 of 1 resident reviewed for elopement (Resident #1). This deficient practice resulted in an Immediate Jeopardy (IJ) to the health and safety of residents who resided at the facility.</p> <p>The State Agency informed the facility of IJ that began as of July 26, 2024 on November 7, 2024 at 2:38 PM. The Facility Staff removed the Immediate Jeopardy on November 13, 2024 through the following actions:</p> <p>a. Exit door where Resident #1 exited is now locked at all times and requires keypad access for egress. Completed on November 8, 2024 by [business name redacted].</p> <p>b. Memory Care residents have been escorted and supervised by designated employee(s) for all programming outside of the memory care since July 29, 2024 implemented by Administrator.</p> <p>c. All residents of [NAME] Center have been evaluated for elopement risk. Completed November 8, 2024 by unit RN managers under the supervision of the Director of Nursing.</p> <p>d. Residents identified to be at risk for elopement living in a non-secured unit have had an electronic wandering protection device placed and care plans have been updated. Completed November 8, 2024 by unit RN managers under the supervision of the Director of Nursing.</p> <p>e. Residents identified to be at risk for elopement living in a secured unit will have an electronic wandering protection device placed no later than Thursday November 14, 2024 by unit RN manager under the supervision of the Director of Nursing. Care plans were updated on November 8, 2024 by unit manager under the supervision of the Director of Nursing to reflect other interventions initiated.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>f. Elopement Prevention policy has been developed and approved on November 8, 2024 by the Administrator.</p> <p>g. All staff scheduled today (11/8/24) have been educated on new Elopement Prevention policy, and all other staff will be educated at start of their next scheduled shift. First shift staff education has been completed by unit RN Managers under the supervision of the Director of Nursing; second and third shift staff will be completed at start of shift today (November 8, 2024) by Unit RN managers and RN evening supervisor under the supervision of the Director of Nursing; and all other staff not scheduled today will be completed at start of their next scheduled shift by [NAME] Center staffing specialist, unit RN managers, or evening RN supervisors under the supervision of the Director of Nursing and the Administrator. All staff are required to complete the education prior to starting their next shift effective immediately (11/8/24). The majority of staff education will be completed by 11/11/24. Any remaining staff or PRN staff who have not worked by 11/11/24, will be trained prior to working their first scheduled shift.</p> <p>h. Additional electronic wandering protection devices were ordered through RF Technologies on November 8, 2024, and RF technologies has confirmed delivery for Thursday November 14, 2024.</p> <p>i. Plans in place:</p> <ol style="list-style-type: none"> 1. Daily checks of resident electronic wandering protection devices to ensure that they are in place and operational are already being completed by nursing staff as of 11/8/2024. Additional residents who receive wandering protection devices will be added to the daily checks as the devices are placed. 2. Weekly door checks - to be completed weekly starting week of November 11, 2024. 3. Elopement drills - to be completed weekly beginning week of 11/11/2024. The Quality Assurance and P Performance Improvement committee will evaluate results and may adjust cadence as appropriate. <p>The scope lowered from a J' to D at the time of the survey after ensuring the facility implemented education and their policy and procedures.</p> <p>The facility reported census was 106.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS), dated [DATE], revealed Resident #1 scored 7 out of 17 on the had a Brief Interview for Mental Status, indicating a severe cognitive impairment. The MDS identified Resident #1 independent with mobility with the use of a walker, requiring supervision with ambulating more than 50 feet with two turns. The MDS listed diagnoses included non-Alzheimer's dementia, diabetes mellitus, and renal insufficiency.</p> <p>An Elopement Risk tool, dated 6/13/24, identified Resident #1 with a total score of 52. The screening tool indicated an Elopement Risk score of 59 or below indicates a low risk for elopement.</p> <p>The Care Plan included a Plan for LTC (Long Term Care) Falls IPOC (Interdisciplinary Plan of Care) initiated on 2/20/24, and LTC ADL (Activities of Daily Living)- Mobility IPOC.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the facility self-report to the State Agency on 7/26/24, Incident Summary revealed [name redacted] is a resident of the [NAME] Memory Care and was attending a group activity in the general common area. At the end of the activity, resident walked out main courtyard doors around south side of the building to the memory care gate. Corrective Action Description: Resident was seen by activity professional, escorted back in the gate to memory care with no further incident.</p> <p>The facility Patient Event: Safety Concern/Safety Event form, date of event 7/26/24 15:00 (3:00 p.m.) revealed, in part:</p> <p>a. Describe Event/Concern: This afternoon during activities in the [NAME] gathering hall, resident exited out of back entrance and started walking around building on the sidewalk. Staff spotted her out of east window and as was able to redirect elder back inside. To prevent this event from occurring again, a wander guard has been placed on her right wrist.</p> <p>b. Could this event have been prevented? Likely could have been prevented</p> <p>c. Describe how the event could have been prevented: Ensuring memory care residents memory care residents at risk for wandering and/or elopement are continuously supervised by trained memory care staff while activities outside of the secured memory care unit.</p> <p>The State Climatologist reported the following weather conditions in [NAME], Iowa on July 26, 2024 at approximately 3:00 p.m.: temperature of 81 degrees F (Fahrenheit), relative humidity 69%, heat index of 85 degrees F, winds out of the ESE (east south east) at 9 mph (miles per hour), with fair conditions and no rainfall reported.</p> <p>During an interview on 11/5/24 at 11:10 a.m. the Administrator stated she was leading an activity group on 7/26/24. Several residents attended, including Resident #1 and at the end of the activity, she was responsible for escorting the memory care residents back to their households. The Administrator stated she did not realize Resident #1 had left their group and veered back into the front lobby area. About ten minutes later Resident #1 was observed through a window, heading East, between the B and C buildings. Resident #1 was immediately escorted back in and found without injury. The Administrator stated there were only two exits Resident #1 could have possibly used to get outside. The front main entrance has two sliding glass doors with a motion detector and a receptionist at the front desk during day hours or a courtyard door at the opposite side of the front lobby which is an unlocked door leading to a courtyard and access to facility grounds. Both exits are unlocked, but have wander guard alarm monitors. The Administrator believed Resident #1 likely used the courtyard door, as it was less visible to the receptionist.</p> <p>During an interview on 11/5/24 at 10:15 a.m., the Activity Director (AD), stated on 7/26/24 there was a group activity in which 15 residents attended, including 5-6 from the memory care halls. The activity was conducted in the main gathering room at the front of the building. It was a Friday, so there was only the AD and the Administrator, who was also the presenter. At the end of the activity around 3:00 p.m., the 5-6 memory care residents exited the room at the southeast door with the Administrator and the others exited the southwest doors and walked towards their halls accompanied by the AD. The AD stated about ten minutes later, as she was walking to her office, she saw Resident #1 walking outside on the sidewalk, between B and C buildings. The AD stated she immediately went outside and escorted Resident #1 back into the building. The AD stated she was not certain what door Resident #1 exited from.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/5/24 at 11:40 a.m., Staff F, Receptionist, stated she was working the day Resident #1 eloped and was at the desk when the 3:00 p.m. activity ended. Staff F stated Resident #1 did not exit through the main entrance doors.</p> <p>During an interview on 11/5/24 at 11:45 a.m., Staff G, Unit Manager, stated she is the Unit Manager on the unit where Resident #1 had resided. Staff G stated Resident #1 was not an elopement risk and never exit seeked while on the unit. Resident #1 usually sat at the dining room table or in her recliner in the living room area. She did not wander or attempt to push doors open. Staff G stated because of her low risk, she was allowed to attend activities off the unit. Residents with high risk for elopement do not attend activities off the unit. Staff G stated instead they have a Recreational Therapist that works with residents and activities on the unit.</p> <p>During an observation on 11/5/24 at 2:00 PM, the facility noted to have an unlocked sliding door facing south at the front entrance. The door is equipped with a motion detector. A receptionist desk, occupied by the receptionist, immediately inside the door and then the lobby area. On the opposite side of the lobby, to the north, is a door to the courtyard. The door found to be unlocked, with a push bar mechanism in place to open. Both the front door and the courtyard doors noted to have a wander guard monitor in place. The courtyard door is not clearly visible from the receptionist desk. Upon walking into the courtyard, there are various concrete sidewalk paths and then a single path that leads around the building. The courtyard area is not secured or the area defined by a fence. North of the courtyard is a grassy area that is well groomed, and leads to a large pond approximately 100 yards away. Access to the pond is open, with no fence or obstruction to entry. Sidewalks lead both east and west around the building. Resident #1 had been discovered on the east side of the building walking on the sidewalk between the B and C wings of the building.</p> <p>During an interview on 11/11/24 at 11:12 a.m., Staff H, Registered Nurse, stated she was responsible for Care Plans and updates. Staff H stated Resident #1 was admitted on [DATE] and determined at risk for falls. Staff H stated Resident #1 had no history of elopement, wandering or exit seeking behavior.</p>		