

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 06/26/2025
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 - Minimal harm or potential for actual harm</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>Based on observation, staff interview, and clinical record review, the facility failed to ensure adequate supervision to ensure a resident remained free from elopement for one of three residents reviewed for supervision/elopement (Resident #1). The resident exited the facility without the knowledge of facility staff on 5/25/25 when the resident left the area where they resided, walked through an unoccupied area of the facility, and exited to outside of the facility. The resident walked around the facility, was seen outside by staff through a window, and was brought back into the facility by staff. The facility reported a census of 115 residents.</p> <p>Findings include:</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #1 dated 4/23/25 revealed the resident scored 3 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, wandering occurred 1-3 days.</p> <p>Review of Resident #1's Care Plan revealed the following dated 11/8/24: LTC elopement risk IPOC.</p> <p>Review of the Investigation Report for Resident #1 dated 5/25/25 at 08:15 revealed the following event description: At the beginning of the shift, approximately 0715 the cna (certified nursing assistant) entered the Resident's room. He was seen to be resting in his bed. At approximately 8:15 am the [Area Name Redacted] Nurse alerted the [Area Name Redacted] staff that she had just seen the Resident outside walking on the sidewalk. On [Area Name Redacted] one cna ran to the south door, the nurse ran to the east door. The nurse saw him walking right outside the door. The nurse opened the door and stated, [Resident #1], would you like to come back in now? Nurse held resident's hand to help him back in the building. Hands warm to touch, vital signs within normal limits, no complaints of pain. The Investigative Notes section of the Investigation Report documented, in part, the following: .It is believed that [Resident #1] followed a new dietary worker out the door while staff was preparing to serve breakfast. The Incident Report further revealed the event could likely have been prevented, and further revealed staff education occurred to check surroundings when entering and exiting the building.</p> <p>Review of the Incident Summary submitted 5/25/25 at 1:44 PM revealed, Resident [Resident #1] followed contracted dietary director employee, [Name Redacted], out of memory care, entered a non-occupied wing of [Facility Name Redacted] and exited the building. Resident was seen from interior of building by [Staff A] RN (Registered Nurse) and immediately redirected back into building by [Staff B] RN and into memory care without incident. No injuries. Staff A found entrance doors to unoccupied area alarming, fire exit door stairwell alarming, and exterior door alarming and all were reset.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/25/25 at 10:23 AM, Resident #1 observed at the breakfast bar in the area of facility where the resident resided. Resident #1 had a wander alert device bracelet present to the left wrist.</p> <p>On 6/25/25 at 10:32 AM, Staff E, Certified Nursing Assistant (CNA) explained some days the resident did wander, sometimes the resident would walk by the door and push on it, explained the resident was confused, said wanted to go home, and would ask about his truck. Staff E explained she could usually reassure the resident and he would calm down.</p> <p>On 6/25/25 at 11:00 AM, Staff A, RN explained, in part, the following: They looked out the window, and saw the resident outside the little courtyard gate. Staff A explained she alerted people on other unit on the neighborhood, staff went out the end of their hallway door, and Staff A went out the front door and around the building to make sure to catch the resident both ways. Staff A further explained staff opened the end door and brought the resident in. Staff A explained she walked down the hall to see how the resident could have gotten out and alarms were going off in the units that were not occupied, which was how it was determined got out that way.</p> <p>Staff A explained the resident's wander alert device was working. Staff A further explained the alarm was going off to the main doors of unoccupied area, and could hear it. When just past the elevators (in hall), Staff A explained she heard the first doors alarming which was why she continued to go that way. Per Staff A, there had been exit doors alarming. Staff A explained the resident came in without any argument or anything, had shoes, clothes, and hat on, sat down, had a cup of coffee, something to eat, and did not appear to be in distress. Per Staff A, [other nurse] had checked him over to make sure it didn't look like had fallen, and [Resident #1] looked fine.</p> <p>Staff A acknowledged she was the first person to see the resident, knocked on the door (to other unit in the neighborhood-neighborhood comprised of 2 units), explained staff could hear her through the glass, and Staff A said [Resident #1] is right there. Staff A explained she saw the resident on the other side of fence (noted to be beyond the courtyard).</p> <p>On 6/25/25 at 11:30 AM, Staff C, Certified Nursing Assistant (CNA) acknowledged she had worked the day the resident had gotten out of the building. On interview, Staff C was unsure when the resident got off the unit. Staff C explained she was down in another room, and when she walked back up, the nurse from the other side, [Staff A], was like Hey, is [Resident #1] over there? Staff C explained she responded he was down in his room, and Staff A said no, [Resident #1's] outside. Staff C explained Staff B, RN and herself went down different hallways. Staff C queried if when Staff A said resident outside, if she (Staff C) saw him (Resident #1)? Staff C confirmed, and explained resident was walking in front of the courtyard. When queried if the resident was inside or outside of the gates, Staff C responded outside the gates. Staff C explained Staff B grabbed the resident's hand and brought him back in.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/25/25 at 11:55 AM, the General Manager for Food Service and Nutrition (contracted employee) explained he had worked the day the resident got out, and explained he had gone into that neighborhood, did rounds, and when left punched the code, opened the door, and did remember someone kind of in that area. The General Manager for Food Service and Nutrition explained he left, didn't look back, and then got a text from a teammate asking if there was someone by the door when he left because there was an elopement. Per the General Manager for Food Service and Nutrition, he came back in and had talked to the nurse. When queried if he could identify the resident in the area if he saw them, the General Manager for Food Service and Nutrition explained it just wasn't what he was looking for, and further explained he just assumed someone had followed him, and because it had happened around that time.</p> <p>On 6/25/25 at 12:08 PM, Staff D, CNA, confirmed she had worked the day the resident exited the building. Per Staff D, she came in to facility and had shift change. Staff D explained she went and grabbed [Resident #1's] laundry, checked on other residents, and brought [Resident #1's] clothes to the laundry room so had clean clothes. Per Staff D, she came back out and waited a little but until turned 7 (AM) when start getting everyone up. Per Staff D, when she looked for the resident's laundry and checked on rooms the resident was there in bed, was awake, and was working on getting dressed. Per Staff D, she came back out, started the resident's laundry, and brought someone out. Staff D explained whoever staff was (on other neighborhood unit) said she found [Resident #1]. When queried if she ever saw [Resident #1] outside, Staff D denied. Staff D was unaware of how long the resident might have been out, was queried if she heard alarms going off during the time, and responded not that she remembered.</p> <p>On 6/25/25 at 1:00 PM, the facility Administrator explained she was alerted of the situation via [facility messaging system] from the Director of Nursing (DON). When queried as to her perspective on why the event had occurred, the Administrator responded when the contracted dietary staff left the resident followed him out the door, and she was not sure if the contracted dietary staff didn't know Resident #1 was a resident, or didn't realize the resident was behind him. The facility's Administrator explained the resident had multiple elopements from other settings prior to being at the facility and did a lot of wandering, which was why the resident lived in memory care.</p> <p>On 6/25/25 at 1:38 PM, Staff B, RN explained the following about the event: Staff B was alerted from a nurse over on the other side that the resident had gotten out. Staff B explained she went one direction, Staff C went another direction, and Staff D stayed to watch the other residents. Staff B explained she was the one who opened the exit door because could see resident walk by. Staff B explained she said, Hey [Resident #1], grabbed the resident's hand, and said, Why don't we come back in? Staff B explained when grabbed the resident's hand was still warm, and resident not out that long because cold out there. Staff B explained when staff were all talking, Staff D said went in there and got resident's laundry at 7/7:15 right after had done report.</p> <p>(continued on next page)</p>		

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