STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165180	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odebolt Specialty Care	801 South Des Moines Street Odebolt, IA 51458

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 to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37074 Based on observations, record review, staff, family and hospital staff interview the facility failed to prevent an accident from occurring for 1 of 3 residents (Resident #1) reviewed for wandering with cognitive impairments. The kitchen staff members left the main kitchen door propped open and unsupervised. Resident #1 self-propelled in to the kitchen, through the kitchen, through two more doors, which included the basement door where she fell down 13 concrete stairs in her wheelchair. A kitchen staff member heard someone yelling for help. She found Resident #1 at the bottom of the basement stairs with her wheelchair next to her. She alerted nursing staff. Staff provided first aide to the left side of her head until EMS arrived and transported her to the hospital. The facility reported a census of 29 residents. On July 10, 2024 at 10:25 AM the State Survey Agency informed the facility of the staff's failure to prevent an accident from occurring for a wandering, cognitive impaired resident created an Immediate Jeopardy situation resulting in the resident going through the kitchen and falling down 13 stairs to the basement of the facility in her wheelchair without staff's knowledge on July 2, 2024. The facility removed the immediacy on July 2, 2024 when the staff implemented the following Corrective Actions: 1) The facility audited all non-resident locked doors in the facility ensuring they were all locked and closed on 7/2/24. 2) The DON, Social Worker and Administrator began to call staff at 9:43 PM on 7/2/24 to educate them that all locked doors must remain shut and locked unless staff are present. 3). Kitchen door will be audited upon completion of meal service daily for two weeks then weekly for 10 weeks. 4) Missing resident drills will be completed on varying shifts daily for 2 weeks then weekly for 10 weeks. Results of the audits will be submitted to QAPI for review and additional recommendations. Findings include: (continued on next page)

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 5/6/24, Resident #1 had severely impaired cognitive skills for daily decision making. The resident did not exhibit rejection of care of wandering during the review period. The MDS documented she did not have impairments to her upper and lower extremities. Resident #1 utilized a walker and wheelchair for mobility. The MDS recorded one fall since her admission/entry, or entry or the prior assessment; whichever was more recent. Resident #1 received the following medications during the review period: antipsychotic, antidepressant, and a diuretic. The MDS documented the following diagnoses for Resident #1: bipolar disorder, dementia, seizure disorder, anxiety, depression, cognitive communication deficit, restless leg syndrome and contracture of left hand. The Care Plan focus area with an initiation date of 4/7/15 documented she was at risk for falls and had a long history of falls. The care plan documented she had anti rollbacks placed on her wheelchair, staff are encouraged to clip her call light cord to her recliner prior to exiting the room. The resident was encouraged to sit in an area of supervision when active and/or restless. Resident #1 received a different wheelchair that may make it easier for her maneuver and control. The Care Plan focus area with an initiation date of 7/10/23 documented Resident #1 was able to propel herself throughout the facility in her wheelchair independently. The care plan indicated the resident will ask for assistance when trying to adjust herself in her wheelchair, she will keep her buttock slid back in the seat of her wheelchair, and will sit in an area with supervision when she feels agitated. The Care Plan focus area with an initiation date of 11/20/23 documented the resident has impaired cognitive function/dementia or impaired thought processes related to dementia. Observations revealed the following: a) On 7/9/24 at 12:20 PM resident laid in her bed sleeping, in the hospital with a gown on, blanket covering her except for her left arm. Noted paper tape-like dressing to her forehead. Also noted numerous bruising to her face, neck, bilateral peri-orbital areas, and left arm. The bruising was of various stages of healing: yellow, dark purple, dark pink/red. b) On 7/9/24 at 12:35 PM the door to the kitchen in the dining room was closed. The door had a key pad on it. A code was needed to unlock the door before entering the kitchen. c) On 7/10/24 at 9:23 AM the door leading to the kitchen from the dining room was closed and locked. A kitchen staff member opened the door. Once in the kitchen, one could walk by the steam table or the prep table, stove and oven. Once on the other side of the prep area was a door with a neon yellow sign that read: this door is to be shut at all times no exceptions. Once through that door, is the pantry door that requires a code entered in the key pad before the door opens. To the right of the pantry door is the basement door with a magnetic box on the wall to keep the door open. The stairwell had 13 cement stairs leading to the basement with wooden hand bars on each side of the stair well. Below the hand rails the walls consisted of cement cinder blocks. The stairs had black and yellow gripper strips at the edge of each stair. The distance from the kitchen door to the basement doorway was 25 steps. The following Progress Notes were documented: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a) On 5/19/24 at 10:52 AM resident was restless this morning before breakfast and had wheeled around the nurse's station around fifteen different times. b) On 6/6/24 at 3:40 PM resident was wandering up and down the hall in her wheelchair. c) On 6/30/24 at 12:13 AM resident was trying to go in to other resident's rooms when propelling herself down the hall. d) On 7/2/24 at 11:33 PM at 6:55 PM Resident #1 was noted to be not up at the nurse's station where Staff A Certified Nursing Assistant (CNA) had brought her after the resident was noted to be propelling herself down hall 2. Resident #1 was not seen until 7:01 PM after Staff C [NAME] found her laying at the bottom of the basement steps in the kitchen. Emergency Medical Service (EMS) was immediately called. From 6:55 PM to 7:01 PM the Social Worker, Staff A Registered Nurse (RN), Staff F CNA, Staff E CNA, and Staff A searched for the resident down each hall twice and outside around the facility. At 7:01 PM Staff C had found resident laying on her right side at the bottom of the basement steps and called for help from the CNAs and the nurse. It appeared that the resident had fallen down 13 steps. Upon assessment Resident #1 had a laceration to her left forehead, left forearm, left cheek, and right middle knuckle. Pressure was held on bleeding wounds; vital signs were checked and neuros started at time of incidence. Resident was talking and asking for help up off the floor. Resident was able to tell staff her name but is unable to tell me what happened. Resident #1's glasses were found, broken on the 5th stair from the bottom. The facility investigation included the following hand-written statements: a) Staff D Dietary Aide wrote she last saw Resident #1 at 6:30 PM at the assisted table and finished her meal. Staff D started cleaning the dining area around 6:45 PM: cleaned tables, emptied glasses, cups, and plates. Around 6:50 PM she heard Staff F yell and Staff C told Staff D that Resident #1 was on the basement floor. Staff D signed and dated her statement on 7/2/24. b) Staff C wrote she last saw Resident #1 at 6:20 PM when she plated the last plate for the meal service. She was still sitting at her table. Staff D went outside at about 6:45 PM for a brief moment to get a breath of fresh air and she forgot to shut the door behind her. When she came back in to the facility, the Social Worker asked if she saw Resident #1, she hadn't. Staff C then walked into the kitchen and found her lying on the floor at the bottom of the stairs. Staff C instantly went searching for CNAs to help her. Staff C signed and dated her statement on 7/2/24. c) Staff E CNA wrote at the time of the incident, he was in a resident's room down hall 3. The last time he saw Resident #1 was around 6:30 PM down hall 2 with Staff B. The resident was brought to the nurse's station then staff went back to work on hall 3. As he came down hall 3, he was asked if he had seen Resident #1. It was expressed that the resident could not be located. Staff E then began to help search for her down hall 2 and hall 3. As he was heading through the assisted living section, he heard someone say we found her. Staff E then came back to see if he was able to assist then went back to helping other residents. Staff E signed and dated his statement on 7/2/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d) Staff B wrote she was in a female resident's room getting her on the toilet at 6:30 PM. She noted Resident #1 was at hall 2 trying to get out the doors. Staff B went to her and said, it's been raining all day. We are not going outside due to the mud outside. Staff B assisted Resident #1 up to the nurse's station with Staff E, while in her wheelchair. Staff B let her out of her sight at 6:50 PM. Staff F came to Staff B and asked for transfer assistance with another female resident. They assisted her to the bathroom, Staff B stated she had another resident on the toilet and let Staff F know she had to help her, so she could finish this resident on her own. Staff B left that room, got to the nurse's station, did not see Resident #1 near there and got worried she was in another room. She went to Staff A and asked if she knew where Resident #1 was and she stated she did not know. Staff A told her she saw her in the dining room moving around in her wheelchair. Staff B then asked Staff F if she saw Resident #1 and she said no, this was about 6:55 PM. They started to look for Resident #1 up and down the halls, she started in hall 2 then hall 1 looking in rooms, before going to hall 3. She went back help the resident she placed on the toilet and got her to bed. When she got out of the resident's room she heard the Social Worker on the phone with the Administrator. Staff B then saw Staff C at the top of the hall yelling help, help, I need someone in the kitchen Resident #1 is at the bottom of the stairs. Staff B ran to the kitchen to note the door to back door open and stair door open with Resident #1 on the bottom of the stairs. Staff B indicated herself Staff A and Staff F were the first to respond. Staff A got vitals as Staff B went to laundry to get towels to put pressure on the wounds and clean up the blood. She told Staff F to use a towel on the resident's arm because there were two open areas. They stayed with Resident #1 until EMS arrived. They had to wait for the fire department to come assist with getting Resident #1 up the stairs. She had a head wound, cheek wound, upper arm, elbow injuries. Staff B was unsure if anything was broken. Staff B signed and dated her statement on 7/2/24. e) Staff F wrote she last saw Resident #1 at 6:50 PM as she took another resident down to her room on hall 1. A co worker assisted her and she had to leave to check on Resident #1. While Staff F went to another resident's room to get her ready for bed, the co-worker knocked on the door and informed her that she could not find Resident #1. Staff F finished assisting the resident she was with, then she assisted with looking for Resident #1. Staff F looked through all the doors and rooms with the Social Worker down hall 2 then Staff F went to hall 1 and looked. She was halfway down hall 1 when the kitchen cook screamed that she needed the CNAs and nurse. The Social Worker, nurse and Staff F ran to the kitchen door that led to the basement and saw Resident #1 lying on the bottom of the stairs. Resident #1 was saying she was hurting and was trying to move. They all told her not to move because they did not know the underlying injuries. Staff F and her co-workers held pressure on Resident #1's wounds. The CNAs and nurse tried to keep her talking and stay awake. The Social Worker called 911 at 7:01 PM. Staff F signed and dated her statement on 7/2/24. f) Staff A wrote the following notes: 1) Last seen Resident #1 at 6:35 PM in the dining room. 2) CNA asked where Resident #1 was, if she saw her lately. They started searching right away. 3) 6:55 PM Staff C alerted nursing staff of Resident #1 being at the bottom of the stairs. 4) 7:01 PM 911 called. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5) Vital signs at 6:56PM: blood pressure 164/108, temperature 97.3-degree Fahrenheit, 92% oxygen saturation, respirations 22, heart rate 88, pupils not constricting. 6) Laceration to left forehead, right forearm, right elbow, bruising/swelling to left abdomen. 7) Range of motion (ROM) to extremities-per resident. Staff A signed and dated her statement on 7/2/24. g) The Social Worker wrote at 6:35 PM a resident came to her asking if she could find his pants. She went down hall 2 to look for them. As she was going down hall 2, Staff B and Staff E had Resident #1 in her wheelchair, assisting her up to the nurse's station around 6:50 PM. After finding the resident's pants, another resident stopped her and asked her to come to his room to look at his TV. After she fixed his TV, as she was walking out of the resident's room Staff B asked if she had seen Resident #1. The Social Worker stated she had not seen her since Staff B was with her earlier. The Social Worker then assisted the CNA to finish looking down hall 3, checked hall 1 next because the CNA stated she already checked hall 2. She called the Administrator at 6:57 PM. The Administrator stated to check all rooms/halls again. Halls 2 and 3 were checked (bathrooms and all rooms), went down hall 1 (all rooms/bathrooms checked). As she was coming back up the hall, she heard the cook stated she needed a CNA ASAP. She followed the cook to the kitchen and Resident #1 was found at the bottom of the back-kitchen steps. The nurse and two CNAs went down to the resident. The nurse asked the Social Worker to call 911, she called the Administrator back letting her know they are calling 911. She called 911 at 7:01 PM. The ambulance arrived at 7:18 PM, but needed lift assistance from the fire department and requested they be called. The firemen arrived and assisted at 7:20 PM. The Social Worker signed and dated her statement on 7/2/24. Review of Resident #1's hospital documents, revealed the following: a) An Emergency Department (ED) Physician Note dated 7/2/24. Resident was seen on 7/2/24 at 7:52 PM for an unwitnessed fall with head trauma. She was found at the bottom of a flight of stairs (13). The fall was not witnessed. Staff was looking for her not knowing where she was when they found her. Resident displayed decreased level of responsiveness, large laceration to her scalp, right leg is somewhat rotated and shortened. Resident complains of pain stating it hurts but not able to describe where. The resident was given intravenous (IV) fentanyl (treatment of severe pain) 50 micrograms (mcg). Medical Decision Making: Fall at nursing home causing facial trauma- CT of head, face, c-spine, chest, abdomen and pelvis were all negative for acute abnormalities. Facial laceration was repaired. Pain medicine was given and she was then much more comfortable. Will place her in the hospital, she qualifies for full admission. Procedure: Laceration to left forehead stellate (pattern like a star), macerated 5 centimeters (cm) total. Area was closed with 7 sutures. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Assessment: 1) Blunt trauma to face 2) Closed head injury 3) Facial laceration 4) Fall at nursing home b) A History and Physical Report with a service date of 7/3/24 documented she was admitted yesterday after she maneuvered her wheelchair down 13 steps at the nursing home. She fortunately has no broken bones but has lacerations and significant contusions primarily on her face and upper extremities. She has long standing dementia and has severe short-term memory issues. Resident resting comfortably today. Review of Systems: Musculoskeletal: positive for back, neck, and joint pain. Positive for decreased range of motion. c) A progress note dated 7/4/24 documented Resident #1 is day 3 acute stay after a fall down 13 stairs at the nursing home. She is confused, which is baseline with multiple bruises to her face and arm. Pain is controlled at this time with fentanyl and Tylenol. d) A progress note dated 7/5/24 documented Resident #1 is alert and oriented to person. She has significant bruising to her face and arms, she has a dressing to her left forehead. Physical Exam: Skin: scattered bruising to arms and face, abrasion to left forehead. On 7/9/24 at 8:55 AM local hospital staff stated Resident #1 came to the emergency roiagnom on the 7/2/24 at around 7:52 PM. She came from the nursing home after falling down 13 steps in her wheelchair. When she came in she had a laceration to her scalp that required 7 stitches, bruises on her head, hands, legs hips, both her eyes, all over basically. She added they did take photos of her injuries. The resident was not able to speak of what happened just complained it hurts. That's all she would say. She currently remains in the hospital as the family is seeking new placement for her. She will remain in the hospital until they are able to do so. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/9/24 at 3:36 PM Staff C asked do I have to relive this again, when she was asked to talk about what happened the evening Resident #1 was found at the bottom of the basement stairs. She had just finished with serving dinner and she forgot to shut the door leading from the kitchen to the dining room. She had asked the dietary aide to shut the door but she did not. Staff C said Staff D was asked to shut the door once she was done assisting another resident. Staff C acknowledged she side tracked and forgot to shut it. Staff C saw Resident #1 at her dining table at 6:20 PM. After meal service, Staff C stated she went outside and Resident #1 fell down the basement stairs. After meal service, Staff C stated she shut down the steam table, starting to do dishes, had just put a load in the dishwasher and went outside to smoke. Once you leave the back-service door it locks so you have to walk around the facility to the front entrance to get back inside. She indicated she was maybe outside for 2 minutes. When asked why the door was open, she stated they do that during meal times when they are taking the food cart in and out of the door for service. She thought nothing of it but then stated they do have a lot of wandering residents. Staff C was unsure how the resident was able to open the basement door because she herself, has a hard time opening in. She stated once inside the kitchen one would have to go around a prep table, two ovens, a steam table and another prep table. You have to go around those areas to get to that door. The Social Worker had asked if she saw Resident #1, so she went in the kitchen to look for her, she did not see her. Staff C started to cleaning and heard someone yelling help, help. She walked through the kitchen, looked in the dry storage area even though that door was locked and closed, she looked anyways. That's when she found Resident #1 on the floor in the basement with the wheelchair on top of her. She immediately went and got help and let the nursing staff take over. Staff C stated she felt like it's her fault and she will never get over what happened. Before this incident it was normal to leave the kitchen door to the dining room open during meal times. Staff C stated it was normal for Resident #1 to wander around the facility in her wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/9/24 at 4:14 PM Staff B stated around 6:30 PM she assisted another resident with using the restroom. She was in there for a few minutes before she left that room. When she left that resident's room she noticed Resident #1 was near the hall 2 exit door. Staff B and Staff E went to assist her away from the door. They let her know it had been raining that day, so it would be too muddy to go outside. They assisted her, in her wheelchair to the nurse's station area. She required eyes on supervision because she will attempt to self-transfer. If they had her at the nurse's station it was easier to keep their eyes on her. The nurse came down hall 2 as they were assisting Resident #1 to the nurse's station. Another co-worker needed help, so after Resident #1 was up at the nurse's station she went to assisted her co-worker. She had noted Resident #1 started to make her way to the dining room area. While assisting her co-worker, she realized she needed to go back to the first resident she had assisted to the bathroom room. Before she went to the other resident's room, she noticed Resident #1 was not at the nurse's station or dining room when she last saw here at like 6:50 PM. Staff B went to the nurse and asked if she knew where Resident #1 was as she could not find her. Resident #1 liked to go down hall 3, so she went there to look for her then went down hall 2 and searched for her with Staff A. When they came up hall 2, they told Staff F we need to find Resident #1, she is missing. Staff B went to assist a resident off the toilet because she had been on it for a long time. Once she assisted her, she took her clothes to the dirty clothes hamper. That's when Staff C came to her and said I need help, I need help, Resident #1 is in the basement of the kitchen. Staff A, Staff B and the Social Worker were the first to respond in the basement around 7:00 PM. They stayed with her, got towels to apply pressure to the open areas to stop the bleeding. Her legs were near the wall and she was lying on her right side. There was a huge gash on her forehead and cheek. Her glasses were broken, the lens was popped out, she had a gash near her elbow, and bruising on her left side. Her wheelchair was not on top of her, looked like someone may have moved it. They stayed with her until EMS showed up and waited for the fire department to come assist with her getting up the stairs. The door from the dining room to the kitchen and the door from the kitchen to the pantry areas where the basement door was ajar, just cracked open. She added the basement door is always opened but was unsure why. Staff B stated the basement door was open when she went down to assist Resident #1 in the basement. Staff will keep the kitchen door propped open during meal service time. When asked if any staff members were in the dining room around the time Resident #1 was in there she stated Staff D was in the dining room cleaning up and charting. On 7/10/24 at 8:04 AM Staff D stated on the day of the incident, she was cleaning up in the dining room. She noted Resident #1 to be at her table finishing up her meal. The resident remained at the table while Staff D was cleaning, this was about 6:45 PM-7:00 PM. Normally the resident would go to the front door to try to get out. She did not see anything that happened just heard what happened. When asked what she heard, Staff D stated she went through the kitchen door, then another door that is never open. The kitchen door was open still because it's much easier to serve food when it's open. But at the time of the incident meal service had completed. When asked who is responsible for closing the door after meal service, she stated the cook is and Staff C was cooking that day. Staff D denied hearing any odd noises that would alarm someone to check the kitchen, while she was in the dining room cleaning. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/10/24 at 8:39 AM Staff A stated she was on hall 2 and the CNAs were on hall 1. At 6:55 PM one of the CNAs asked if she knew where Resident #1 was, as she had just left her up at the nurse's station. She told the CNA before she went down hall 2 she saw the resident in the TV are with other residents present, this was not unusual for her. That was the last time she saw Resident #1. At that time, they started their elopement process. All the CNAs, dietary staff and Social Worker were alerted, they called the Administrator and DON as well. One of the cooks came out and said Resident #1 was at the bottom of the basement stairs. Resident #1 was lying on her right side, right arm under her, and laying on the right side of her head, looking up at the stairs with her knees on the wall. She had blood coming form the left side of her head. Her wheelchair was at the bottom of the stairs with her. Resident #1 complained that her head hurt but was unable to tell them what had happened. She just kept saying my head hurts, my head hurts, please help me. They called 911, she completed an assessment, called the family and was taken to the ER. Her supervision level at that time was like the other resident's in the facility. They would do frequent checks on her. That day she was in her wheelchair, tootling around. Staff A was unsure if the kitchen door was open that evening but thought it must have been because a code is needed to open the door. She was also unsure if the basement door was open at the time of the incident but indicated it did not require a code to be opened. When asked how Resident #1 spent her days, Staff A stated she would wander around, find her in other resident's rooms and bathrooms. It was not uncommon to see her out and about. They are pretty vigilant about where she is when she is wandering around the facility. On 7/10/24 at 9:23 AM Staff H [NAME] stated the basement door is usually always opened. She added they go down there to get resident's clothing protectors, towels, washcloths and hand towels to use in the kitchen. She indicated it's a fire door so it will stay open unless the fire alarm is triggered. On 7/10/24 at 11:29 AM the Social Worker stated she was still at the facility the evening Resident #1 was found on the basement floor. She had a resident come ask her for some assistant in looking or some pants. After she assisted the resident she noticed Staff B and Staff E were assisting Resident #1 up the hall in wheelchair. She went to the front desk when another resident asked for her assistance on hall 3. Once she assisted that resident Staff B had asked if she saw Resident #1. She told Staff B she last saw her on the hall 2 with staff. The Social Worker went down hall 1 to start their search, she called the Administrator to let her know they were unable to find the resident. She was advised to double check each hall again, looking in all the rooms, bathrooms, any open spaces. On her way up hall 1, Staff C stated she needed assistance as she found the resident at the bottom of the steps outside the kitchen. The Social Worker ran there with Staff A, Staff B and Staff F. They went down stairs, she called 911, the Administrator and the family. The last time she saw the resident was at 6:55 PM at the nurse's station, she called the Administrator at 6:57 PM. She noted the nurse was passing medications and there was a dietary aide cleaning in the dining room. She also noted the kitchen door was open when they went to assist the resident in the basement. After she went through the kitchen door she closed it. She did acknowledge the basement door was opened when they arrived. She added the basement door was a fire door and was held open by a magnet mechanism. If the fire alarm sounds, the door will automatically shut. The resident was lying on her right side, legs were propped on the bottom step and her wheelchair was off to the side of her. When asked what Resident #1's supervision level was at the time of the incident she stated she was to be kept in highly supervised areas. If she noticed Resident #1 was anxious, she would do an extra activity with her. She was always on the move, which was normal for her. That day she was alert and moving around in her wheelchair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165180	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odebolt Specialty Care	801 South Des Moines Street Odebolt, IA 51458

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 to resident health or safety Residents Affected - Few	On 7/10/24 at 1:40 PM Staff G CNA stated she has noticed the door in the dining room to the kitchen propped open but was unsure if the door once inside the kitchen are left open. She stated prior to the incident with Resident #1, staff would keep the door to the kitchen propped open during meal service while they passed out trays. On 7/10/24 at 1:57 PM the DON stated she got a call from the facility at 6:59 PM stating Resident #1 was missing. At 7:03 PM they called her back to report they found her and had called 911. She arrived the facility at 7:20 PM just as the ambulance crew and firemen were lifting her out of the basement. The DON saw the resident briefly before she left for the hospital. She noted the following: she was able to move her extremities, doing her grimacing moans which was normal for her, noted a laceration to her forehead and could not visibly see a skin tear. She started her witness statements, made sure all doors were locked that were to be locked, completed a head count and ensured everyone was accounted for and safe. When she arrived to the facility the kitchen and basement doors were shut. When asked if their investigation revealed what door(s) were left opened she stated through interviews they were never able to determine what door(s) was open. Staff C told her a door was open but did not specify which door it was. At the time of the incident the DON reported staff were to keep an eye on her frequently as she was known to propel herself around the facility. They would see her down a hall and could redirect her to the nurse's station where she could have closer supervision in a high visual area. During their education with staff it was discussed that the kitchen door to the dining room needed to be shut immediately after the last plate is served. The door is to remain shut. The door between the kitchen and hall where the pantry, basement and back door is located is to remain shut at all times. On 7/10/24 at 3:09 PM Staff E stated prior to the incident he believed the kitchen staff had been told a couple of times to keep the kitchen door closed. When the door would be opened, it would be during meal service or taking dishes back to the kitchen. He added when the door is open the cook was always in the kitchen. The day of the incident the kitchen door was open and when he went through the kitchen to assist Resident #1 in the basement, the basement door was open too. Staff E stated Resident #1 was pretty quick when propelling herself in her wheelchair. On 7/10/24 at 3:44 PM the Administrator stated she got a call that evening about a missing resident. She instructed staff to check all the rooms again and double check everywhere inside. The Social Worker called her back and stated the resident had been found. Just as she arrived at the facility the ambulance had left with the resident. When asked what her investigation revealed she stated they believed the door from the dining room in to the kitchen was left open. They have sent started to do audits to make sure that does not happen again. She denied seeing that door being propped open previously. When asked if any of their staff interviews revealed any other doors that were left open on the day of the incident, she stated no one mentioned that to her. The facility provided a document titled Safety Precautions with a revision date of November 2009. The Policy Statement included, all personnel shall follow general safety precautions by this facility. The policy directed staff to follow established safety precautions as well as those that may become necessary or appropriate.