STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Washington	601 E Polk St Washington, IA 52353

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336 Based on clinical record review, facility policy review and staff interview the facility failed to provide adequate staff supervision to prevent a severely cognitively impaired resident identified at high risk for elopement, with wandering behavior from elopement on 10/21/24 for one of one resident (Resident #1) reviewed for elopement. The resident exited the building through an unlocked, unalarmed front door. The resident self-propelled her wheelchair out the front door, through the parking lot to the back of the building at an unknown time. Staff found the resident at approximately 6:30 AM when they exited the building for a break. The resident found with a wheel of her wheelchair stuck on the edge of the concrete, unable to move. This deficient practice resulted in an Immediate Jeopardy (IJ) to the health and safety of the residents who resided at the facility. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of October 21, 2024 to October 23, 2024 at 10:38 AM. The Facility Staff removed the Immediate Jeopardy on October 23, 2024 through the following actions: a. Resident #1 was assessed immediately by the licensed nurse; no injuries noted. b. Medical Director notified of elopement on 10/21/24 by the Director of Nursing. c. Resident #1 responsible party notified on 10/21/24 by the Director of Nursing. d. The Medical Director notified on 10/22/24 for medication review due to increased behaviors; a medication increase for Seroquel was ordered for stabilization. e. All exit door alarms will be monitored every 2 hours to ensure alarms are armed and functioning appropriately. If a failure is noted, the door will be monitored by staff 24 hours a day/7 days per week until the alarm is functioning properly. The elopement monitoring tool will be updated daily during the morning meeting by the Administrator and or Director of Nursing. (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	f. On 10/21/24, the dining room has 24 hours per day, 7 days per week monitoring by staff to ensure no failures occur. Monitoring will occur until the Magnetic Locks with keypads are installed by the vendor, when the vendor equipment is available. In the absence of a scheduled staff member, the Administrator and/or Director of Nursing will monitor the dining room door. Department heads will be scheduled in two-hour increments during the day shift 6 AM to 6 PM and then nursing staff will be assigned to monitor from 6 PM to 6 AM daily. g. 100% review of all current residents identified as elopement risk was completed on 10/21/24 by the Licensed Nurses and/or Social Service Director. 11 out of 36 residents were identified for elopement risk. Each resident identified as an elopement risk was placed in an updated elopement binder at each nursing station of the facility. h. The facility Elopement Policy was reviewed on 10/22/24 and included the safety of resident, unplanned absence, comprehensively assess/evaluate the resident for the risk for elopement, assist the Interdisciplinary Team to develop a plan and provide a resident with a safe and secure environment, utilize individualized interventions to maintain a resident's safety within the facility by the Senior [NAME] President of Clinical Services. i. In-service education for staff regarding the Elopement Policy was initiated on 10/21/24 by the Nursing Home Administrator and or Director of Nursing and is ongoing with new staff and agency staff that included the elopement assessment, Implementation, Elopement risk, Evaluation and evaluating the outcomes (Weekly reports, elopement monthly drills and as needed, and during the Quality Assurance Performance Improvement meeting monthly) with staff. j. No staff shall work until they have completed in-service education regarding Elopement. Staff will be in-serviced and educated on Elopement including safety of residents, unplanned absence, comprehensively assess/evaluate the resident for the risk for elopement, assist the Interdisciplinary Team to develop a plan and provide a resident with a safe an secure environment, utilize individualized interventions to maintain a resident's safety within the facility standardized process to evaluate effectiveness of interventions through care planning process and make changes as necessary to elopement, analyze trends and validate sustained improvement by the Administrator. The Administrator will monitor elopement education needs weekly to ensure staff is in-serviced prior to working schedule shift. k. Newly hired staff will be in-serviced on elopement with regards to unsafe wandering, identifying and reporting Risk to Elopement or Actual Elopement (if a there is an unplanned absence of a resident all department heads will search the facility and premises and after 15 minutes if resident is unfound the local police department will be notified providing police with the most recent full body photograph, an close up face photograph and information in the elopement binder), Investigation process, unplanned absence of a resident, assist with developing a plan and provide a resident with a safe and secure environment, utilize individualized interventions to maintain a resident ' s safety within the facility, evaluate the effectiveness of interventions through care planning process and make elopement changes as necessary, trend and validate sustained outcomes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	l. Ad hoc Quality Assurance Performance Improvement meeting was conducted on 10/22/24 regarding Elopement Management. The Administrator and Director of Nursing will monitor for patterns and trends and report to Quality Assurance Performance Improvement Committee weekly for 4 weeks and quarterly, thereafter. Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes identified. 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. The facility reported a census of 36 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 scored a 2 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident had delusions. The MDS assessed the resident required substantial/maximal assistance to sit to stand, chair/bed-to-chair transfer, and to walk 10 feet. The assessment identified the resident normally required a walker or wheelchair for mobility. The MDS revealed Resident #1 experienced two or more falls, with no injury, since the last assessment. The MDS listed diagnoses included stroke, diabetes mellitus, non-Alzheimer's dementia, seizure disorder or epilepsy, depression, and bipolar disorder. The MDS identified the resident taking medications in the high-risk drug classes of antipsychotic, antidepressant, opioid, and hypoglycemic (medication used to lower blood sugars) The Care Plan, date initiated 1/11/23, revision on 10/21/24 included a Focus area to address [Name redacted] is an elopement risk/wanderer r/t (related to) history of attempts to leave facility unattended, impaired cognition, and poor safety awareness. [Name redacted] wanders aimlessly and had the potential to significantly intrude on the privacy of other residents. Elopement on 9/29/24 and on 10/21/24 with no injury. Interventions on the Care Plan included: a. 10/21/24 Elopement, No injury. Intervention -15-minute checks for 24 hours, 15-minute checks when exit seeking behaviors, Nurse checklists to check door alarms at night. Staff education on relocking doors immediately after use. Date Initiated: 10/21/24. b. 9/29/24 Elopement Intervention - medication management and 1:1. Dated Initiated: 9/29/24. c. 9/29/24 Elopement Intervention - Velcro STOP sign placed on front door. Date Initiated: 9/29/24. d. Assess for fall risk. Date Initiated: 1/11/23 e. Distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: [no text completed]. Date Initiated: 1/11/23. f. elopement 6/5/23. Date Initiated: 6/5/23. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/22/24 at 10:55 AM, Staff B, CAN/CMA stated she didn't hear an alarm and when other staff talked about it, nobody heard an alarm. Staff B stated no one knew she [Resident #1] was outside until Staff A found her and that was when they did a head count. Staff B stated breakfast was served at 7:00 AM and no staff would of been in the dining room because they started to get people up and that morning we were short staffed so she helped the 2 CNA get people up. Staff B stated the kitchen didn't open their door until they were ready to serve. Staff B stated Staff A usually took his medication cart up front before 6:30 am so when residents came to the dining room, staff was down there. During an interview on 10/22/24 at 12:01 PM, Staff E, CNA stated she was told about Resident #1 being outside. Staff E stated she didn't hear an alarm but she was in a room. Staff E stated she became aware of Resident #1 being outside when someone popped their head in the room and said we needed to do a head count and let me know Resident #1 got outside. Staff E stated she seen Resident #1 five minutes before and she thought she was going to breakfast because she saw her in the 300 hall going to towards the dining room. During an interview on 10/22/24 at 12:11 PM, the DON stated she received a call around 6:30 AM from Staff A and he explained what happened and that the CNAs seen Resident #1 about 6:15 AM and no one was in the dining room and the next time he saw Resident #1 she was outside. The DON stated she asked what the resident wore when she was found outside and asked about the door alarms and Staff A stated they didn't go off. The DON stated the alarms were usually set and she didn't know why they weren't this time. The DON stated Resident #1 probably went outside looking for her car because she used to work there as a CNA when she was younger. The DON said no one heard an alarm. The DON queried on the hazards for Resident #1 being outside and she stated the weather had been cooler in the morning and the possibility of her getting out of her wheelchair and walking without her walker. During an interview on 10/22/24 at 12:29 PM, the Administrator stated she spoke to the visitor that came to the building on Sunday evening and he described the staff member who let him out. The Administrator called the CNA and they said they locked the door and heard the chirps and they closed the double doors that lead to the dining room at 10 PM. The Administrator stated somehow the door was not alarmed. The Administrator stated Resident #1 couldn't have been outside more than 5 to 10 minutes max. The Administrator queried on the hazards of Resident #1 being outside and she stated the temperature could be and the vehicles on the road but she didn't think Resident #1 would go to the road, she would go and look for her car in the parking lot to go home. The Administrator stated no one said they heard an alarm at the time of the incident. The Administrator stated she did not think the alarm malfunctioned because Staff A turned it on. The Administrator stated she felt like this incident was human error and the plan of correction will be a keypad. During an interview on 10/23/24 at 1:28 PM, the Administrator stated the egress door put in late Friday and training for the door started on Monday. She stated the egress door is currently being used and they were working on getting a key pad in place to ultimately correct the issue. The Administrator stated she concluded a CNA on third shift let a visitor out around 8:15 PM on Sunday 10/20/24 and turned the key to left to arm the alarm and then right to pull out the key and she thought the CNA might have pulled the key too far to the right and unarmed it. The Administrator stated she expected staff to make sure the doors were alarmed properly. A review of the undated facility policy, titled Elopement Management, Identifying and Reporting an Actual Elopement section revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165453	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire of Washington	601 E Polk St Washington, IA 52353

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	Definition: Elopement occurs when a resident leaves the facility or a safe area without authorization .If a resident is on facility property but not under supervision as needs identifies; then an elopement has occurred.