STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165607	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Cottages	1742 Main Street Pella, IA 50219

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 - 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** 35434 Based on observation, clinical record review, policy review, and staff interviews, the facility failed to provide additional interventions, and supervision after Resident#1 displayed exit seeking behaviors. The facility also failed to secured the facility's exterior doors so that cognitively impaired residents could not leave the building without staff knowledge. This resulted in Resident #1 leaving the building without the staff's knowledge in 29 degree Fahrenheit weather. The staff only realized Resident #1 had left the building when a visitor found Resident #1 lying on the ground. This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident and for 3 of 3 additional cognitively impaired, independently mobile residents with access to this door (Residents #5, #6, #7). The facility identified a census of 93 residents. The State Agency (SA) informed the facility of the Immediate Jeopardy (IJ) on 2/19/25 at 3:35 p.m. The IJ began on 1/26/25, the day Resident #1 left the facility without staff's knowledge. Facility staff removed the Immediate Jeopardy on 2/20/25 through the following actions: -Wanderguard (a system that uses bracelets, sensors, and technology to monitor residents and prevent wandering) placed on Resident #1. -Staff education regarding elopement policy, elopement drills, significant change assessments, response to door alarms. -Elopement assessments on all residents with a Brief Interview for Mental (BIMS) score less than 11. -Sign place on exit doors for families as reminder to not assist someone out the door and to notify team members. -Alarms activated on egress doors in Overijessel (OV) and Utrecht (UT) households -Barrel lock installed on patio door connecting OV/UT -Remote notification alarm installed between the long-term care area and the assisted living area -Door lock installed on Gelderland household dining room door. (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 - Some	The scope lowered from K to E at the time of the survey after ensuring the facility implemented education and their policy and procedure. Findings include: The Significant Change in Status Minimum Data Set (MDS) assessment tool for Resident#1, dated 12/27/24, listed diagnoses which included senile degeneration of the brain, heart failure, and depression. The MDS stated the resident required substantial to maximal assistance for standing and partial to moderate assistance for walking. The MDS listed the residents Brief Interview for Mental Status (BIMS) score as 3 out of 15, indicating severely impaired cognition. Care Plan entries, dated 5/31/23, documented the resident had short and long term memory impairment and had confusion as to date, time, and family members. The facility Elopement Precautions Policy, updated July 2024, stated the facility had electronic door alarms which sounded when opened and should remain activated at all times. The policy also documented that any resident, regardless of location , if consistently exit seeking should have an electronic monitoring device. An 11/13/24 Care Plan entry stated the resident required the assistance of 1 staff with a walker. A 12/1/2024 at 3:36 p.m. Behavior Note stated the resident was very agitated and stated (the facility) was holding him there and he wanted to go outside. The resident kicked below the window in the dining room and tried to pull the window sill out to put the window up. Review of the Care Plan revealed that the facility staff did not identify Resident #1 as displaying potential elopement warning signs on 12/1/24, and the facility staff did not implement any additional nursing supervision interventions to address Resident #1's increased elopement risk. A 12/15/2024 at 4:20 p.m. Nurses Note stated the resident became very confused. He pushed his walker and thought he was driving and was trying to get back to [city name, city where resident currently resided]. Review of the Care Plan lacked additional nursing supervision interventions after Resident#1 displayed potential elopement warning signs on that were documented in a Nurses Note dated 12/15/24. A 12/26/24 at 5:48 p.m. Elopement Evaluation stated the resident was not at risk for elopement. A 1/14/2025 at 8:40 p.m. Incident: Post Follow Up note stated the resident remained confused and not able to sit still. The note stated he could not be trusted to stay in his chair and he tried to stand up and walk without his walker. The resident required constant attention and staff carried out regular checks. A 1/26/2025 Nurses Note stated at 4:45 p.m. a Certified Nursing Assistant (CNA) alerted that the resident was outside and fell in the grass. The resident sat in the grass in front of the sister cottage by the sidewalk. He wore a sweatshirt, white undershirt, knit pants, socks, and shoes. The resident stated he saw an animal outside and went out to get it. The resident had bilateral (referring to both sides) knee abrasions. The facility placed a Wanderguard on the resident's ankle. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 2/19/25 at 10:35 a.m., Staff A Registered Nurse (RN) stated a family member held the door out for Resident #1 as they did not think he lived in the facility. She stated she saw the resident about 5 minutes before the family members left the building. She stated Staff B Certified Nursing Assistant (CNA) informed her that another family member drove by and saw the resident outside. Staff A stated the resident sat in the grass close to the sidewalk. The resident stated he was outside because he went after two hogs. Staff A stated after this incident, staff placed a Wanderguard on the resident and tried not to place him by doorways. On 2/19/25 at 11:15 a.m., Staff B CNA stated a visitor informed her a resident laid outside on the ground. She informed the resident's nurse via radio (Staff A) of this. Staff A assessed the resident and then they assisted him back inside. On 2/19/25 approximately 11:20 a.m., the SA exited the OV household (Resident #1's household) and did not need a code. The door did not alarm when opened and led outside to a patio area and a walkway towards a street in the middle of the facility campus. On 2/19/25 at 12:20 p.m., Staff C CNA stated on the morning of the incident, the resident was a little confused and she got him settled down and reminded him that it was winter. He went to the front door to look outside. She stated she saw the resident 10 minutes before another CNA told her he was outside. On 2/19/25 at 12:26 p.m., Staff D CNA stated towards the afternoon the resident became a little more confused, was looking for his family, and wanted to walk. She stated (prior to him leaving the building) she found him in the breezeway in between the two double doors. He stated he looked for his family. She stopped him and got him turned around and he wanted to sit on the bench located near the door. She and Staff C made sure to cycle past to check him ever 20-30 minutes. She said she last observed him approximately 30 minutes before staff found him outside. She stated the exit doors to the resident's building did not require a code to get out during the day. On 2/19/25 at 1:39 p.m. the Executive Director stated for Resident #1's building, no code was required to exit. She stated there was not another way to lock down that door. She stated if a resident tried to exit the building earlier in the day, she would want staff to monitor them more closely. On 2/19/25 at 3:07 p.m., the Senior Clinical Quality Specialist stated they placed locks on the doors of Resident #1's building. She stated if one did not enter a code, the door would alarm. On 2/19/25 at 3:07 p.m., the Executive Director stated when they reviewed the camera footage, they observed that a visitor did not let the resident out, but he went out independently. An untitled list, provided by the facility on 2/19/25, indicated 3 independently mobile residents with a BIMS less than 11 resided in OV and UT. This list did not indicate Resident #1 met this criteria. A tour of the facility on 2/20/25 revealed the following concerns: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a. Staff E Maintenance Staff opened the Gelderland household exterior dining room door at 8:39 a.m. No alarm sounded but Staff E stated the alert would go to staff phones. As of 8:46 a.m., no staff had responded to the door or inquired as to why the door alerted. At 8:46 a.m. a staff member came out to the dining room table and her phone was not with her. Another staff member, Staff E CNA came out of a resident room also at 8:46 a.m. with a pager. She at first said that she did not hear the alert but then said she did not respond to it because she was with a resident. b. The doors to the South [NAME], Gelderland, and Groningen households did not require a code to exit and did not alarm upon exit. Residents had the ability to exit these households and enter a hallway which led toward the Friesland Assisted Living (AL). The AL entry doors were open and no alarm or code system was in place in order to enter the area. Once in the AL, a door to the laundry room was open which led to a hallway and to an unlocked door which led outside. c. A door in a connecting hallway between the OV household and the UT household was unlocked and led out to an enclosed courtyard. The hallway was not locked and residents had access to the door. On 2/20/25 at 1:35 p.m. the door in the connecting hallway between the OV and UT households had a lock installed on it. A tour of the facility on 2/24/25 at 8:00 a.m. revealed a door lock on the Gelderland dining room door and an alert notification on the door leading into the AL. On 2/26/25 at 9:41 a.m. the State Climatologist stated the temperature in [NAME], Iowa at 4:00 p.m. was 29 degrees Fahrenheit.