STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E050	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buchanan County Health Center	1600 First Street East Independence, IA 50644

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on observation, record review, staff interviews, and policy review the facility failed to ensure 1 of 5 mobility independent residents that were reviewed with severe cognitive impairment were kept in a safe location on the facilities premises at all times (Resident #1). On 10/30/2024 at 1:38 PM Resident #1 exited the facility by using an unlocked door and entered the attached Independent Living facility without an alarm sounding resulting in staff unaware of her exiting the building, however was in a safe place on the facilities premises. At 1:44 PM Resident #1 then exited the facilities Independent Living and went into the parking lot of an unsafe location off premises where she attempted multiple times to open an unknown person's vehicle car door until approximately 2:15 PM (31 minutes). A serious adverse outcome did not occur, however, was seriously likely to occur because staff were unaware she left the building and was outside in the Independent Living parking lot without staff supervision. The facility reported a census of 35 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) on 11/25/24 at 2:12 PM. The IJ began on 10/30/2024, the day Resident #1 exited the building from the attached Independent Living facility. Facility staff removed the Immediate Jeopardy on 10/31/24 through the following actions: a. On 10/30/24 at approximately 2:30 PM a Wander Alert System was installed on doors exiting the nursing facility into the Independent Living Facility. b. Hourly Checks of the doors exiting the nursing facility into the independent living facility to ensure they were secure and verify an employee badge or badge assigned to an independent living facility resident was required to be scanned to open the doors. Continues to remain in place. c. On 10/31/24 at approximately 8:30 AM door locks changed on doors exiting the nursing facility into the Independent Living facility to prevent the door from being left unlocked. In the event a key is used to unlock the door, the key must be returned to the locked position before it is able to be removed from the lock. This ensures the doors are locked at all times. The deficient practice was identified as past non-compliance and the scope lowered from J to D on 10/31/24 prior to the survey when the door lock was replaced. (continued on next page)

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	Findings include: The Minimum Data Set (MDS) for Resident #1 dated 8/8/2024 documented a Brief Interview for Mental Status of 3 out of 15 indicating severe cognitive impairment. The MDS also documented she was independent without assist devices for walking, transferring, and toileting and had no impairment in her upper or lower extremities. The MDS also revealed she had Alzheimer's disease and anxiety disorder. An undated and untitled document provided by the facility of the timeline of events for Resident #1 exiting the facility documented the following investigation that occurred on 10/30/24: a. 1:35 PM Resident #1 observed in her room by Staff A, Certified Nurse Aid (CNA) b. 1:38 PM Resident #1 exited the nursing facility into the Independent Living part of the nursing facility. c. 2:00 PM Staff A informed Staff B, Registered Nurse (RN) Resident #1 was not in their room d. 2:13 PM A tenant who lives at the Independent Living called the local police reporting a concern Resident #1 had attempted to open the door of a vehicle several times but was unable to as the vehicle was assumed to be locked. c. 2:15 PM Staff B observed two Independence police officers outside in the parking lot. During an observation on 11/25/24 at 10:05 AM revealed all doors throughout the facility locked and alarmed. Walk through of path Resident #1 took when exiting the facility on 10/30/24 into the Independent Living part of the building with the Administrator revealed she was outside next to a highway not visible by any windows of the nursing facility in a parking lot. Record review on 11/26/24 at 11:53 AM the Administrator provided a list of current residents that were independent in the building and their BIMS score: Resident #2 BIMS 6 (severe cognitive impairment) Resident #3 BIMS 3 (severe cognitive impairment) Resident #4 BIMS 0 (severe cognitive impairment) Resident #5 BIMS 8 (moderate cognitive impairment) Resident #6 BIMS 6 (severe cognitive impairment) During an interview on 11/25/24 at 9:53 AM Staff C, Maintenance revealed he has worked at the facility for over [AGE] years and the door into the Independent Living part of the building has never been unlocked, and he was unsure how it would ever be unlocked. During an interview on 11/25/24 at 10:07 AM - 10:17 AM Staff D, [NAME] and Staff E, Maintenance revealed there was no way the door into the Independent Living would ever be able to be left in an unlocked position as the door mechanics have been changed. (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 11/25/24 at 11:13 AM the facilities Administrator revealed Resident #1 was outside for approximately 31 minutes unattended on 10/30/24 and was wearing a long sleeve sweatshirt, jeans, and sneakers and the temperature was 73 degrees. She informed Resident #1 attempted to get in one vehicle but it was locked, the road next to the parking lot speed limit is 30 miles per hour (mph). During an interview on 11/26/24 at 10:13 AM Staff F, Activities Coordinator revealed she would provide one-on-one activities for Resident #1 as she did not really enjoy any group activities. It was hard to get her to them, however Resident #1 would come to coffee talk or Bingo and then she would just get up and leave in the middle of it. She then informed you had to speak up when you talked to her and sometimes you would say something and she would not understand. She then stated Resident #1 had a very quick gait and could move very fast and was very mobile and did not use a walker or cane. She informed that sometimes nursing staff would ask her to provide one to one activity with her to keep her busy and they wanted eyes on her at all times. Her confusion was up and down and she changed everyday, never knew what to expect with her. During an interview on 11/26/24 at 12:26 PM with Staff G, Licensed Practical Nurse (LPN) informed Resident #1 was very busy and not a morning person, but sometimes she would be up for 24 hours or more. She needed a lot of supervision but she was independent and would keep an eye on her from a distance because she could get upset at times and informed the facility recommended to Resident #1 family she needed to be placed in a memory unit as she was very busy, and very quick on her feet. She revealed she felt Resident #1 might have been able to start a vehicle if the keys were in it, but it would have all depended on her cognition at that moment as it varied a lot. During an interview on 12/26/24 at 12:45 PM Staff B, RN revealed Resident #1 would try and go outside a lot with no specific door, but when she was in that mood they would provide one to one with her so she could have eyes on her constantly. She revealed Resident #1 would make random comments about how she needed to leave for something, and it would change all the time, she then informed she felt she never understood. She then revealed on a good day she would make zero (0) attempts to exit the facility and make up to five (5) attempts to exit the facility on her worst day. She informed Resident #1 could probably turn a vehicle on if it needed a key, depending on the make model of the vehicle, but not a push button vehicle. She informed if a vehicle was honking at Resident #1 she does not think she would have been able to comprehend what that meant. If someone would have pulled over when she was outside and offered her a ride, a stranger or anyone she would have got in the vehicle with them. During an interview on 11/26/24 at 1:05 PM with Staff H, LPN revealed Resident #1 sometimes would be up for 24 hours or more, and you never knew what you would get from her from day to day. She was independent with walking. She liked to be tidy and doing something, she would change her clothes multiple times a day, sometimes three (3) or more as she would forget. She informed she worked the day Resident #1 got into the Independent Living part of the building and was searching for her but no alarms were going off so assumed she had to still be in the building. (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 11/26/24 at 1:22 PM Staff I, CNA revealed Resident #1 could get combative and aggressive. She informed Resident #1 wandered a lot and was pretty quick on her feet, but everyday was different for her, sometimes she would be in bed all day and sometimes up all night. She revealed Resident #1 would look for her purse and jacket a lot, and sometimes would go to the front door and tell staff she lost her purse or keys and say she was going to get in her car and drive home. She then informed Resident #1 probably could have started a vehicle but not sure if able to drive and could have possibly tried to get a ride with someone. During an interview on 11/26/24 at 1:34 PM Staff J, CNA revealed Resident #1 loved to wander and the facility let her unless it became a hazard. She then informed most of the time you could redirect Resident #1 by asking her if she could help you, because if something else needed her attention she would go towards it right away. She then revealed it worried her with Resident #1 living at the facility because she was so fast, you would see her one second and then the next second she would be gone. During an interview on 11/26/24 at 1:42 PM Staff K, CNA revealed on a normal day Resident #1 would stay in her room as she had a mind of her own and it was hard to redirect her. On a good day she was very happy, but on bad days she would try to go out doors 5-6 times a day and the facility would provide one on one with her. She revealed she felt Resident #1 probably could have waved a vehicle down for a ride if she was outside and wanted to go somewhere. She was independent with walking and had a normal pace, but always had to carry something in her hands like a purse, doll, or blanket whatever she could find. During an interview on 11/26/24 at 1:48 PM Staff L, CNA revealed she works at the facility full time and Resident #1 was usually pretty quick with walking but she never really worked with her and did not know what things would have helped her when she was door seeking During an interview on 11/26/24 at 1:53 PM Staff M, agency contracted CNA, revealed Resident #1 was a hard resident to take care of as she was going to do what she wanted to do and was very hard to redirect. She informed Resident #1 was very fast and they could never keep track of her. She was very feisty and would like to yell at people and would talk about breaking into her house and say get out of my house. She also would pack all her things in trash bags we actually had to take out the extra bags in her room because would fill them up with her stuff and haul all of it out in her arms and also take her clothes out of the closet and bring them up to the nurses station and lay them on the table then go get more. Sometimes she would be awake for up to 36 hours and then sleep 24 hours, she did that about once every few weeks. During an interview on 11/26/24 at 2:23 PM the Administrator revealed you could not be firm with Resident #1, instead ask if she could help with something and switch out caregivers if it's not working. She informed she would have expected the Independent Living door to always be locked as this was the first time it had ever failed since she started in her role 10.5 years ago. Review of the facilities policy, Abduction and Elopement of Patients/Residents last reviewed on 9/25/24 instructed the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Elopement: A resident who leaves when doing so may present an imminent threat to the patient's health or safety because of legal status or because the patient has been deemed too ill or impaired to make a reasoned decision to leave. Elopement does not include events involving competent adults with decision-making capacity who leave against medical advice or voluntarily leave without being seen. Identification of those at Risk for Elopement and Prevention Measures: Interventions will be individualized based on the resident's risk. Interventions may include but are not limited to: a. Placement in a room close to the nursing station if possible. b. Use of an alarm system to alert staff of patient movement (bed/chair alarm) if appropriate. c. Frequent rounding on patient/resident by staff to identify any potential unmet need. d. Resident will be accompanied by staff when leaving the unit. e. Staff will verbally redirect residents as needed for their safety. f. Documentation of resident's elopement risk will be included in the resident's care/treatment plan. g. Any attempted elopement will be shared during the staff shift report and documented in the medical record.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 41537 Based on record review and staff interview the facility failed to implement a comprehensive care plan with resident specific interventions to assist with identified exit seeking behaviors for 1 of 4 residents reviewed (Resident #1). The facility reported a census of 35 residents. Findings include: The Minimum Data Set (MDS) for Resident #1 dated 8/8/2024 documented a Brief Interview for Mental Status of 3 out of 15 indicating severe cognitive impairment. The MDS also documented she was independent without assistive devices for walking, transferring, and toileting and had no impairment in her upper or lower extremities. The MDS also revealed she had Alzheimer's disease and anxiety disorder. Record review of Resident #1 Care Plan on 11/21/24 lacked resident specific approaches and interventions of what to do when exit seeking. During an interview on 11/26/24 at 12:26 PM Staff G, Licensed Practical Nurse (LPN) informed Resident #1 needed a lot of supervision because she could get upset at times and informed the facility recommended to Resident #1 family she needed to be place in a memory unit as she was very busy, and very quick on her feet. Her family recommended she watch TV and have a bowl of ice cream when going to bed upon admission, and we tried but it never worked. Her daughter came up a lot in the evening and did bedtime routine. During an interview on 12/26/24 at 12:45 PM Staff B, RN revealed Resident #1 would try and go outside a lot, no specific door, but when she was in that mood they would provide one to one with her so she could have eyes on her constantly. She would fold towels sometimes or plastic toy babies, but you never knew how long your intervention would last. We would try to think of something to keep her occupied sometimes it would be towels, food, or we would walk with her and and redirect as needed. During an interview on 11/26/24 at 1:34 PM Staff J, CNA revealed Resident #1 loved to wander around the facility and staff let her unless it became a hazard. She informed Resident #1 really liked picking up trash or clothing protectors in the dinning room as she needed to keep her hands and mind busy. She then informed Resident #1 was used to being a Mom so things like coloring didn't work, she wanted to be in a Mom role. During an interview on 11/26/24 at 1:42 PM Staff K, CNA revealed on a normal day Resident #1 always had to carry something in her hands like a purse, doll, or blanket whatever she could find. She also had a few fake cats and kittens she would hold, she also had a few plastic toy babies and would treat them like they were real and then say, you know they are not real. During an interview on 11/26/24 at 1:48 PM Staff L, CNA revealed she worked at the facility full time and never really worked with Resident #1 and did not know what things would have helped her when she was door seeking. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/26/24 at 1:53 PM Staff M, agency contracted CNA revealed Resident #1 loved cleaning and needed Mom type interventions such as cleaning the dining room. During an interview on 11/26/24 at 2:23 PM the Administrator revealed you could not be firm with Resident #1, instead ask if she could help with something and switch out caregivers as needed. She informed she would expect a Care Plan to have specific interventions for wandering behaviors if present and be personalized to each resident.