

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: #6666		Date: 10/3/17	
Facility Name: Accura Healthcare of Pleasantville		Survey Dates: September 6, 7, & 12	
Facility Address/City/State/Zip 909 North State St. Pleasantville, IA 50225		Fine amount reduced by 35% to \$325.00 on October 11, 2017 pursuant to Iowa Code Section 135C.43A	
Rule or Code Section	Nature of Violation	Class	Fine Amount
		Correction date	

50.7(4)	481—50.7(10A, 135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(4) When a resident elopes from a facility. For the purposes of this subrule, "elopes" means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff.	II	\$500	On Receipt
58.28(3)e	481—58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) 58.28(3) Resident safety e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) DESCRIPTION: Based on record review and staff interview, the facility failed to give timely notification of a resident's elopement from the facility (Resident #3). Elopement means a resident with impaired decision making ability left the facility without staff knowledge. The facility reported a census of 45 residents. Findings include:			

Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

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	<p>According to the Minimum Data Set (MDS) assessment tool dated 7/5/17, Resident #3 was admitted to the facility on 6/29/17, had a diagnosis of non-Alzheimer's dementia and experienced severely impaired cognitive status. The MDS documented Resident #3 was independently mobile and required limited assistance with dressing, toilet use and personal hygiene.</p> <p>Progress Notes dated 7/8/17 at 1:52 p.m., revealed Resident #3 had gone to the (secured) patio area as was common for this person. Both aides working that afternoon were in the dining room area and observed Resident #3 walk past the dining room windows. The aides immediately left the building, approached Resident #3, and escorted him/her back into the facility. Upon investigation of the elopement, it was discovered two planks on the wooden fence surrounding the courtyard were removed and Resident #3 squeezed through the opening, which the facility repaired.</p> <p>In an interview on 9/12/17 at 11:40 a.m., the Administrator reported on 7/8/17 Resident #3 exited The Lodge (locked CCDI - chronically confused demented individual - unit) (secured) courtyard; he/she removed two boards and slid through the fence. Staff discovered the resident when he/she walked by the dining room windows. The Administrator stated he did not report the incident because they believed it was a "witnessed" elopement.</p>			
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	FACILITY RESPONSE:			
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