

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

Citation Number:		Date: 10/3/17		
#6666		Fine amount reduced by 35% to \$325.00 on October 11, 2017 pursuant to Iowa Code Section 135C.43A		
Facility Name: Accura Healthcare of Pleasantville		Survey Dates: September 6, 7, & 12		
Facility Address/City/State/Zip  909 North State St. Pleasantville, IA 50225				
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
50.7(4)	<p>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):</p> <p>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.</p>	II	\$500	On Receipt
58.28(3)e	<p>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)</p> <p><b>58.28(3) Resident safety</b></p> <p>e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)</p> <p><b>DESCRIPTION:</b></p> <p>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.</p> <p>Findings include:</p>			

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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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	<b>FACILITY RESPONSE:</b>			
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