

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

<b>Citation Number:</b> 6942				
		<b>Date:</b> 4/10/19		
<b>Facility Name:</b> Hiawatha Care Center		<b>Survey Dates:</b>		
<b>Facility Address/City/State/Zip</b>		3/10/19, 3/11/19, 3/12/19, 3/13/19 and 3/14/19		
400 North 15 <sup>th</sup> Ave Hiawatha, IA 52233		JS		
<b>Rule or Code Section</b>	<b>Nature of Violation</b>	<b>Class</b>	<b>Fine Amount</b>	<b>Correction date</b>

<b>58.28(3)e</b>	<p><b>58.28(3) Resident safety.</b> 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, observation, and interview the facility failed to provide adequate supervision to prevent hazards from self and elements in the environment (elopement) for 1 of 10 identified at risk for elopement. Resident #184 has a history of wandering and exited the building without staff knowledge and was found outside in the snow. The facility reported a census of 105 residents.</p> <p>1. The MDS (Minimum Data Set) assessment dated 3/4/19 revealed Resident #184 had diagnosis of dementia with behavioral disturbance and hallucinations. Resident #184 had severe cognitive impairments.</p> <p>The MDS dated 3/4/19 revealed Resident #184 required extensive assistance of 1 staff for transfers and walking. The MDS documented Resident #184 wandered for 1-3 days during the 7-day look back period. Resident #184 had significant risk of getting to a potentially dangerous place.</p> <p>The Care Plan dated 2/26/19 revealed Resident #184</p>	<b>I</b>	<b>\$8,000 (Held in Suspension)</b>	<b>Upon Receipt</b>
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Facility Administrator

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	<p>had hallucinations and directed the staff to allow to share prior experiences on farm, share farm photos, medicate as ordered by physician and social service staff to offer one on one support if inappropriate with mood/behaviors.</p> <p>The Progress Notes dated 3/1/19 4:17 p.m. revealed Resident #184 attempted to go out two different doors.</p> <p>The Progress Notes dated A 3/3/19 11:45 p.m. revealed Resident #184 attempted to push the door open and staff explained to the resident the door had an alarm on it and it was very cold outside.</p> <p>The Progress Notes dated 3/4/19 3:00 a.m. revealed Resident #184 up and down "tonight", wandering in the hall and visiting with staff.</p> <p>The Progress Note dated 3/4/19 5:20 a.m. revealed at 5:00 a.m. Resident #184 not in his room and the staff searched the southwest hall. The staff exited the front door and found Resident #184 outside next to the second window on the right end of the building. Resident #184 had on 1 slipper sock and a hospital gown open in the back. Resident #184 had his incontinent brief around his ankles. The staff placed a jacket on Resident #148 and called for assistance. Resident #184 had 1 superficial scratch to the right elbow.</p> <p>According to the National Weather Service's (<a href="http://www.weather.gov">www.weather.gov</a>) climatological data for Cedar Rapids, Iowa on 3/4/19, the low temperature was -9</p>			
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	<p>degrees Fahrenheit with a high temperature of 7 degrees Fahrenheit.</p> <p>Facility documentation provided to the State Agency after the elopement stated the resident's body temperature was 96.3 degrees Fahrenheit on 3/4/19 at 5:25 a.m.</p> <p>During an interview on 3/12/19 at 5:01 a.m., Staff K (Licensed Practical Nurse) reported she heard the alarm sound, went to Door 3, observed the Velcro sign on the door undisturbed, looked out the window, did not see anything, silenced the alarm and went back to her work. Staff K reported 10 to 15 minutes later Staff P (Nurse Aide) asked if she knew Resident #184's location. Staff K reported they searched and found Resident #184 outside wearing a hospital gown and had a brief around his ankles. Resident #184 informed the staff he was fixing the air conditioner. Staff K stated called for assistance. The staff assisted Resident #184 indoors and completed an assessment. Staff K reported she did not receive education regarding door alarm protocol upon hire. Staff K stated she did not know she should not have silenced the alarm and should have completed a perimeter check. Staff K reported she received training after this elopement. The Assistant Director of Nursing told Staff K there was a plan to implement a training checklist so all staff receive the same training.</p> <p>During an interview on 3/11/19 at 07:13 p.m., Staff P (Nurse Aide) reported Resident # 184 was at the Nurse's Station when she arrived to work at 10:00 p.m.</p>				
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	<p>Staff K Licensed Practical Nurse (LPN) assisted Resident # 184 to bed around 4 a.m. Later, during rounds, Staff P observed Resident # 184 out of bed and banging/tearing down the toilet paper holder. Staff P continued with rounds. Staff P then heard another resident calling out for help because Resident # 184 was in their room. Staff P assisted Resident # 184 back to his room and went back to rounds. Staff P heard the door alarm sounded and it went off right away. Staff P finished completing cares and went to check Resident # 184. Staff P checked Resident #184's room and then other resident's rooms and could not find Resident #184. Staff P noticed the Velcro strip in place across the door at the end of the Resident #184's hall. Staff P asked Staff K about the location of Resident # 184. Staff K acknowledged clearing the door alarm, looking outside, and not seeing anyone. Staff P reported she went to look for Resident #184 outside. Staff P reported Resident # 184 was found outside standing in the snow. Resident #184 had on one grip sock, a t-shirt and had brief around the ankles. Staff P reported Resident # 184 stated, "was working" and allowed the staff to assist him/her back in the building. Staff P reported 10 to 15 minutes lapsed from the time she heard the alarm sound and when Resident # 184 was brought back in the building. Staff P stated Resident # 184's skin was cold to touch and his body temperature was low per Staff K. Staff P reported Resident #184 did not have a wander device place to alert the staff when exiting. Staff P reported Resident #184 had a normal routine of getting up at that time of the day.</p>			
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	<p>During an interview on 3/12/19 at 5:25 a.m., Staff L (Registered Nurse) reported she helped assist the Resident #184 indoors. Staff L stated it was "so, so cold" that night and the staff had to shovel Resident #184's wheelchair out of the snow.</p> <p>During an interview on 3/12/19 at 5:38 a.m., Staff M (Nurse Aide) reported the staff shoveled Resident #184's wheelchair out of the snow. Staff L stated it was "cold" out and the cold and it got in her chest. Staff M reported Resident #184 wandered on other shifts and they had him sit by the nursing station.</p> <p>During an interview on 3/12/19 at 6:20 a.m., Staff N (Nurse Aide) stated Resident #184 was a busy, back and forth in the hall, wandering into other resident rooms and looked out the window a lot.</p> <p>During an interview on 3/12/19 at 6:27 a.m., Staff O (Nurse Aide) stated Resident #184 had delusions and talked about the "farm across the lake". Staff O reported when an alarm sounded staff should go outside to look around.</p> <p>During an interview on 3/12/19 at 8:48 a.m., Staff F (Assistant Director of Nurses) stated after the elopement she went over the door alarm protocol with Staff K. She stated she did not know if there was paperwork on hire for Staff K. Staff K reported a plan to implement a checklist for new hires that included alarms. Staff F reported this elopement was the first time she knew of Resident #184 exit seeking.</p>				
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	<p>During an interview on 3/12/19 at 9:37 a.m., the Administrator stated he received a phone call that Resident #184 eloped. The Administrator stated if a resident was an elopement risk, they would have a wanderguard. The Administrator reported he spoke to Staff K. The Administrator reported Staff K should have left the alarm sounding and completed a head count. The Administrator stated he did not think the resident tried to get out the doors prior to the elopement.</p> <p>During an interview on 3/12/19 at 9:58 a.m., the DON (Director of Nursing) stated if an alarm sounded, she would not silence it until she knew the cause and stated she would have opened the door and looked out. She stated they did not have documentation Staff K signed upon hire regarding door alarms but stated moving forward they would go over the policy with all new hires. She stated the facility implemented a wanderguard for the resident after the elopement and stated she would place a wanderguard on a resident who tried to get out the door. She stated she was not aware the resident had exit seeking behavior prior to the elopement.</p> <p>Care plan entries, dated 3/4/19, stated the resident had the potential for wandering and directed staff to answer door alarms per protocol and to walk outside and walk around corners, monitor and check the roam alert weekly and wanderguard daily.</p> <p>A 3/7/19 care plan entry stated the resident wandered out the facility and directed staff to monitor the</p>			
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	<p>resident's whereabouts in the building.</p> <p>The undated Door Alarm Policy directed staff to identify which door alarmed and to go to that door and check for a resident outside. The policy stated this might require the staff member to go outside and check for a resident in the surrounding area.</p> <p>The undated New Admission Risk Assessment Elopement Decision Tree policy stated if a resident had a history of wandering or opened doors to the outside, or made statements they were going to leave, staff would apply a wanderguard to the wrist or ankle.</p> <p>The Door Alarm and Elopement In-Service Training Conducted sheets revealed the facility completed staff training on 3/8/19.</p>			
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