

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: #8089		Date: September 1, 2002		
Facility Name: West Point Care Center		Survey Dates: August 10 – 17, 2020		
Facility Address/City/State/Zip 607 6 th St West Point, IA 52656		VM HL JS		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
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>58.28(3) Resident safety.</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>DESCRIPTION:</p> <p>Based on observation, record review, and interview, the facility failed to adequately supervise a cognitively impaired resident who eloped for 1 of 4 sampled (Resident #1). A facility staff heard the front door alarm sound, responded and allowed Resident #1 to exit the facility without supervision. The other staff had no knowledge that the resident exited the facility. A community member from a town 10 miles away alerted the staff Resident #1 was sitting on the front porch of Resident #1's home. The facility identified 4 residents as independently mobile and cognitively impaired. The facility reported a census of 29.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The Minimum Data Set (MDS) assessment dated 7/30/20 revealed Resident #1 had dementia, psychotic disorder, and schizophrenia. The resident required 	I	\$7, 500 (Held in Suspension)	Upon Receipt

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	<p>limited assistance of 1 staff for bed mobility, transfers, walking, dressing, toilet use, personal hygiene, and bathing. The resident had a Brief Interview for Mental Status score of "5" indicating severely impaired cognition.</p> <p>The Care plan entry dated 7/23/20 revealed the resident independent with mobility but required assistance with activities of daily living due to Alzheimer's dementia and delusional disorder</p> <p>The Nurses Notes dated 7/27/20 at 12:30 a.m., stated the resident walked out in the hallway.</p> <p>The Nurses Notes dated 8/6/20 at 12:14 a.m., revealed on 8/5/20 at 10:30 p.m. Resident #1's neighbor called and stated the resident was at the resident's house in Fort Madison approximately 10 miles from the facility. The staff verified the resident was not in the building and drove to the resident's home to pick her up. The resident arrived back at the facility at 11:30 p.m.</p> <p>The Nurses Notes dated 8/6/20 at 2:54 a.m. revealed since the resident returned to the facility a staff member sat outside the resident's room.</p> <p>The updated Care plan entry dated 8/6/20 revealed the resident had an elopement risk due to a history of attempts to leave the facility and directed staff to monitor the resident's location every 30 minutes, check wander guard placement every shift, and carry out one on one with the resident while in isolation.</p>				

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	<p>During an observation/interview on 8/12/20 at 12:00 p.m., the resident sat in her room with her suitcases near her. The resident voiced a desire to go home.</p> <p>During an interview on 8/12/20 at 10:20 a.m., Staff A (Housekeeper) stated between 8:00 p.m. and 10:00 p.m. she heard the front door alarm. She stated she silenced the alarm and allowed Resident #1 out the door. Staff A thought the resident was a visitor.</p> <p>During an interview on 8/12/20 at 10:58 a.m., Staff C (Nurse Aide) stated she was the last staff to see the resident before she left the building. Staff C saw the resident at 8:30 p.m. in the bathroom while she was taking care of another resident in an adjoining room.</p> <p>During an interview on 8/12/20 at 2:15 p.m., Staff B (Registered Nurse) stated on 8/5/20 at around 10:15 p.m., Resident #1's neighbor (from the community) called and stated the resident was at the resident's home in Ft Madison. The resident was on the porch. Staff B confirmed the resident was not at the facility and began to follow the elopement protocol.</p> <p>During an interview on 8/12/20 at 11:37 a.m., the Director of Nurses (DON) stated she was in the building the night of 8/5/20 for an employee meeting. She stated around 10:00 p.m. Staff B informed her the resident was in another town (Fort Madison). They confirmed the resident was not in the building. She and Nurse Aide drove to Fort Madison, picked the resident up, and brought her back to the facility.</p>			

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	<p>During an interview on 8/12/20 at 12:00 p.m., Resident #1 was unable to recall how she got to her home when she left the facility.</p> <p>During an interview on 8/12/20 at 2:00 p.m., the DON stated upon initial admission, the family informed the facility one of their concerns for the resident was safety which required placement in the facility.</p> <p>During an interview on 8/13/20 at 9:17 a.m., the Administrator stated if a staff member was unfamiliar with a person who was leaving the building, they should check with the charge nurse.</p> <p>During an interview on 8/17/20 at 11:50 a.m., the Administrator stated the facility did not conduct elopement drills in the last year.</p> <p>The undated facility policy "Door or Personal Alarm Policy" directed staff to visually check to see who set off the alarm and if it was a resident, assist them back inside.</p> <p>A Resident List Report dated 8/12/20 identified 4 residents in the facility as cognitively impaired and independently mobile.</p> <p>On 8/13/20 at 11:45 a.m. the State Agency informed the facility of the Immediate Jeopardy.</p> <p>The facility abated the Immediate Jeopardy on 8/12/20 by conducting assessments of all residents to identify</p>			

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	<p>residents at risk, updating policy and procedure for visitors exiting the facility, a plan to educate newly hired staff on procedure for signing out visitors, staff education on updated policy, a plan to conduct weekly audits to ensure staff retention to educational materials, and a plan to conduct behavior audits.</p> <p>After the corrective actions the scope and severity lowered from "J" to "D".</p> <p>FACILITY RESPONSE:</p>			

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