STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165569	A. BUILDING _____ B. WING _____	C 08/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST POINT CARE CENTER INC	607 6TH STREET PO BOX 398 WEST POINT, IA 52656

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 8/18/2020 A COVID-19 Focused Infection Control Survey and facility reported incident #92672 were conducted on August 10 -17, 2020. Facility reported incident #92672-I was substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 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.	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marian R Johnson RN — TITLE: Administrator — (X6) DATE: 9/3/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/30/20 revealed Resident #1 had dementia, psychotic disorder, and schizophrenia. The resident required 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. 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 The Nurses Notes dated 7/27/20 at 12:30 a.m., stated the resident walked out in the hallway. 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. 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. 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	F 689		

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F 689	Continued From page 2	F 689		

every shift, and carry out one on one with the resident while in isolation.

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.

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.

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.

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.

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

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F 689	Continued From page 3	F 689		

her back to the facility.

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.

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.

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.

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.

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.

A Resident List Report dated 8/12/20 identified 4 residents in the facility as cognitively impaired and independently mobile.

On 8/13/20 at 11:45 a.m. the State Agency informed the facility of the Immediate Jeopardy.

The facility abated the Immediate Jeopardy on 8/12/20 by conducting assessments of all residents to identify 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

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F 689	Continued From page 4 on updated policy, a plan to conduct weekly audits to ensure staff retention to educational materials, and a plan to conduct behavior audits. After the corrective actions the scope and severity lowered from "J" to "D".	F 689		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete an annual performance review for 3 of 3 Nurse Aides sampled (Staff C, Staff D and Staff E). The facility reported a census of 29. Findings include: 1. An undated and untitled sheet documented the facility hired Staff C (Nurse Aide) on 3/15/18, hired Staff D (Nurse Aide) on 1/28/19, and hired Staff E (Nurse Aide) on 6/15/11. Review of the Employee Files for Staff C, Staff D, and Staff E revealed the facility failed to complete a performance review in the last 12 months. The undated facility policy "Employee Evaluation Policy" stated the facility would carry out employee evaluations on an annual basis to provide staff with feedback.	F 730		

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F 730	Continued From page 5 During an interview on 8/17/20 at 2:00 p.m., the Business Office Manager stated the facility was behind on the completion of performance reviews due to a transition in department heads. During an interview on 8/17/20 at 2:45 p.m., the Administrator stated she was working on completing an action plan to complete the performance evaluations.	F 730		

West Point Care Center Plan of Correction for a Facility reported incident # 92672 that was conducted on August 10-17, 2020 Provider # 165569

F000 Preparation and/ or execution of the plan of correction does not constitute admission or agreement by the provider or the truth of the fact alleged or conclusion set forth in the statement of deficiencies. The plan of corrections is prepared and or executed solely because it is required by the provision of federal and / or state law.

F 689 Free of Accident Hazards / Supervision / Devices

- On 8/5/2020 Resident #1 was provided with 24 hour one on one observation to assure she did not try to elope again and to remain safe in the building at all times.
- To protect all residents in a similar situation:
    1. An audit was done for all residents with behaviors to identify additional residents that might be at risk through both behavior documentation and elopement scores. All residents received a new elopement risk assessment and any resident found to be at risk from the audit and the assessments had a new Wander guard monitor placed on their person.
    2. The Policy and Procedure for Missing Person was updated to include new admissions are now being assessed for elopement weekly times 4 weeks and then with each OMRA MDS to better identify residents at risk for elopement sooner.
    3. The Policy for having visitors exit and Proper procedure for staff to follow was updated. Staff was educated on this policy and procedure.
- Measures being taken to ensure that the problem does not recur include:
    1. Staff education on Policy and Procedure for Visitor exiting and the Policy and Procedure for Missing Person will be ongoing and included in the new hire packet.

2. Random audits of staff retention of visitor exiting will be completed by all department heads 3 times weekly times 3 weeks and then weekly times 3 weeks.
3. The director of Nursing or designee will do an audit regarding behaviors called the Behavior Summary Report that includes wandering. This is to assess any change in behaviors that might lead to elopement. This will be ongoing

- Results of all education audits will be presented to the quality assurance committee monthly ongoing for further recommendations.
- Results of all elopement assessments will be monitored in the daily stand up meeting by all department heads and communicated to staff daily in the communication book ongoing. Results of this communication will be reviewed by the QAPI committee for further recommendations.

F 730 Nurse Aide Performance Review

- On 8/17/2020 and audit of all staff annual evaluations was completed by the HR Business office. By 8/18/2020 all Nursing Department evaluations were made up to date and reviewed with the employee.
- Education was provided to all department heads on the chapter 58 regulatory guidance on employee evaluations.
- Measures taken to ensure the problem does not recur:
  1. On the first of each month the HR business office will provide all departments will a list of all evaluations due at for the following month. This list will be discussed and readdressed one time a week ongoing until all evaluations are completed.
- To assure the solution is permanent: monthly evaluations will be discussed at the QAPI meeting for further recommendations regarding staff education needs.