DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290360	A. BUILDING: _____ B. WING _____	C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDIAPOLIS CARE FACILITY	142 NORTH ORCHARD MEDIAPOLIS, IA 52637

(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) COMPLETE DATE
R 000	Initial Comments The following deficiencies were cited during the investigation into Complaint #91053-C as well as the onsite infection control survey:	R 000		
R 266	481-57.7(5)b General Requirements 481-57.7(135C) General requirements. 57.7(5) The licensee shall: b. Be responsible for compliance with all applicable laws and with the rules of the department. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to comply with requirements related to notifications to the Department found in Iowa Administrative Code 481 - Chapter 50. Findings follow: A review of incident reports and resident files revealed the facility failed to notify the Department of elopements as required by Iowa Administrative Code rule 50.7 (4). The Program Director confirmed this finding. See deficiency under 50.7 (4) for details.	R 266	1/12/21	
R 373	481-57.11(7) Personnel 57.11(7) Orders for medications and treatments. Orders for medications and treatments shall be correctly implemented by qualified personnel. (I, II, III)	R 373		

1/7/21
1/12/21

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R 373	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to correctly administer medication for 1 of 6 current residents (Resident #4) and 3 of 4 former residents reviewed (Residents C2, C3 and C4). Findings follow: 1. Record review on 10/6/20 revealed Resident #4's July 2020 Medication Administration Record (MAR) indicated she was to take Linzess 290 mcg. once daily. Handwritten on the July MAR was the word HOLD on the dates of July 8, 9, 11, 12 and 13. HOLD was also written on the dates of July 9, 10, 11, 12, 13, 14, 15 and 18 for the medication Polyethylene Glycol, 17 grams/8oz. once daily. Resident #4 was to take Senna 17.2 mg. daily but HOLD was written on the dates of July 9, 10, 11, 12, 13 and 18. There was no corresponding order from Resident #4's physician noting these medications should have been held on these dates. 2. Resident C2 was admitted to the facility on 2/28/20. According to his admission orders dated 2/26/20, he was to take the following medications: Fluoxetine, 60mg. one pill daily; Mirtazepine, 7.5mg. one pill at night; Hydroxyzine HCL, 50mg. three times a day; and Librium, 25 mg. four times a day. When Resident C2 arrived at the facility, his February and March 2020 MARs noted he was to take Mirtazepine, 15mg. at bedtime rather	R 373	Corrected Orders for all medications and treatments shall be correctly implemented by qualified personnel. Qualified staff will administer all medications and treatments at the designated times ordered by the primary care provider in the correct dosage. Specifically, Clozapine medication will be monitored by the Director of Nursing and/or designated nursing staff to ensure all appropriate lab orders will be conducted in a timely manner. Communication will be enhanced with the pharmacy where the medications will be distributed from. No medication will be accepted into said facility from such pharmacy without being reviewed and analyzed by Mediapolis Care staff to ensure the correct medications in their correct dosages and correct numbers are delivered and signed off on appropriately. The Pharmacy will no longer be allowed to "drop" off medications of any kind without a signed document that each party agrees what is being delivered and received. The pharmacy manager has agreed to the above statements. Lab draws for members will continue to be	1/7/2021

Connie Schwartz Adams 12/29/2020

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R 373	Continued From page 2 than 7.5 mg. The MARs also indicated his Hydroxyzine was to be taken as needed, when the order said three times daily. Librium was not listed on either MAR. Resident C2 received new orders from his primary care provider on 3/27/20 changing his Mirtazepine to 15mg. at bedtime as needed. A Vitamin B complex vitamin was added to his medication list. No changes were made to his other medications. The Vitamin B complex vitamin was never added to Resident C2's MAR and therefore never administered to him. 3. Resident C3 was admitted to the facility on 2/21/20 at 3:30 PM. His February 2020 MAR indicated he was to take the medication Clozapine, 150mg. in the morning and 200mg. at night. Clozapine is an antipsychotic medicine according to Drugs.com which works by changing the actions of chemicals in the brain. Clozapine is used to treat schizophrenia after other treatments have failed. Clozapine is also used to reduce the risk of suicidal behavior in people with schizophrenia or similar disorders. According to the February 2020 MAR, Resident C3 did not receive his morning dose of Clozapine on February 22 or 23. The MAR was blank with no reason given for not administering the medication on these days. A review of the March 2020 MAR revealed Resident C3 did not receive his morning dose of Clozapine on March 1, 2, 3, 5, 6, 19, 20, 25 and 26. He missed his evening dose of Clozapine on March 1, 2, 3, 5, 6, 13, 19, 25 and 26. All days but the morning dose of the 19th were marked as the pill being unavailable. The May 2020 MAR notated Resident C3 did not receive his morning dose of Clozapine on May 1, 2, 3, 4, 7, 12 or 13. Resident C3 missed his evening dose of Clozapine on May 1-14.	R 373	documented. If the PCP or psychiatry provider fails to send the lab order to the lab, Mediapolis Care staff will document this error and notify the provider that was to order the lab. If the lab draws the incorrect lab and labels it incorrectly or utilizes the incorrect tube, which requires Mediapolis Care staff to return to the lab with the resident for an additional lab draw, this will also be documented by the Mediapolis Care staff and the provider that ordered the lab will also be notified as well as the laboratory manager. The DON will oversee and monitor all medications & treatments. These are monitored daily.	

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Nurse's notes revealed on 5/4/20, Resident C3 shouted gibberish, refused to attend groups and stormed out of rooms. On 5/5/20, he was defiant and refused to partake in lab draws, however later in the day Owner/Director 2 was able to get Resident C3 to get his lab draws. Per the results of the lab draw his medication should have been restarted. On 5/11/20, Resident C3 yelled at multiple staff, screamed and threw punches in the air. The DON (Director of Nursing) noted she was trying to get Resident C3 an appointment with a psychiatric provider as his had recently resigned. She maintained his weekly labs in order to keep getting his Clozapine. Resident C3 was noted to be delusional and confused all evening on 5/19/20. On 5/20/20, Resident C3 urinated on his window sill and slapped the Administrator in the face. He became combative and 911 was called. He was transferred to the hospital and later discharged from the facility.

4. Record review revealed Resident C4's January 2020 MAR indicated he was to take 300mg. of Clozapine at bedtime. He did not receive this medication from January 11-19. A review of the February 2020 MAR showed Resident C4 did not receive Clozapine from February 1-18. He did not receive the medication on April 18-20 according to the MAR.

5. An interview was conducted with the nurse at the office of the psychiatric provider for Residents #4 and C4 on 10/15/20 at 8:10 AM. She reported all medication refills and lab requests received for these residents were processed within one day.

6. The pharmacy for the residents was also contacted as they assisted the facility with filling the Clozapine for the residents once required lab

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work was completed. The pharmacist reported facility staff was to take a resident for labs 2-5 days before their Clozapine ran out, then notify the pharmacy the labs had been drawn. Resident C3 was entered into the pharmacy's system on 3/3/20 and an emergency supply of Clozapine was sent to the facility that same day. The pharmacy received the results of the lab work on 3/6/20. The facility did not take Resident C3 for his lab work in May until 5/5/20. The pharmacy delivered Clozapine to the facility for Resident C3 on 5/5/20, although according to the MAR it was not administered to the resident.

The pharmacist reported they only sent out a 19 day supply of medication to Resident C4 on 12/23/19. She did not know why a 28 day supply of medication was not sent out, but speculated it was all the medication the pharmacy had on hand. The facility did not contact the pharmacy for additional medication until 1/20/20 and the pharmacy then sent out 9 more pills at that time. Resident C4 did not have his lab work completed for his Clozapine until 2/19/20 enabling him to get his refill for the 2/1-18/20 period. The pharmacy sent Clozapine to the facility on 2/19/20. His lab work was completed on 4/21/20 which accounted for the missing medication on 4/18-20/20 as the pharmacy sent out a refill on 4/21/20.

7. The Administrator, DON and Program Director were interviewed about medications on 10/13/20 at 2:25 PM. The DON reported an RN had the ability to hold medications and the nursing judgement to hold Resident #4's meds in July was appropriate. The facility contacted Resident #4's ARNP on 10/13/20 and she reportedly said it had been appropriate for the nurse to hold Resident #4's medication in July 2020. They reported Residents C3 and C4 saw the same

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R 373	Continued From page 5 mental health practitioner who did not fill medication refills and lab order requests promptly which led to residents going for periods of time without Clozapine. They also stated the pharmacy did not deliver the Clozapine according to the delivery sheets.	R 373		
R 374	481-57.12(135C) General Policies 481-57.12(135C) General policies. The licensee shall establish and implement written policies and procedures as set forth in this rule. The policies and procedures shall be available for review by the department, other agencies designated by Iowa Code section 135C.16(3), staff, residents, residents' families or legal representatives, and the public and shall be reviewed by the licensee annually. (II) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow the general policies laid out in their COVID-19 handbook. Findings follow: 1. Review of the facility's COVID-19 handbook on 10/8/20 revealed when there was a suspected or confirmed outbreak of COVID-19, staff were to wear a mask, face shield and gloves when caring for residents. This was also to be the procedure when staff were delivering medication and meals to the residents in their rooms when they were quarantined. Staff C reported on 10/13/20 at 1:15 PM she wore a face mask and gloves when she entered the	R 374	Corrected In the event that a resident has COVID-19, staff will only enter their bedroom or designated quarantine area wearing a face mask, a face shield, and gloves in order to care for resident(s). In addition, if a resident has a temperature of 100.4 degrees or above, their PCP will be notified, any and all directives that the resident's PCP gives will be implemented and adhered to. All staff will follow the COVID-19 policy of Mediapolis Care and will continually be updated if and as policies may need to be changed. The DON will manage + oversee the COVID-19 Policies.	1/7/2021

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R 374	Continued From page 6	R 374		

room of a resident who had tested positive for COVID-19. She used hand sanitizer after leaving the room.

The Program Director reported on 10/13/20 at 1:40 PM she wore a mask and gloves when she entered the room of a resident who had tested positive for COVID-19. She washed her hands after leaving the room. The Program Director said face shields were provided to staff but staff were not required to wear them when entering the room of a resident who had tested positive for COVID-19.

2. According to the policy, if a resident had a temperature greater than 100.4, staff were to notify the resident's doctor to review symptoms and request a COVID-19 test.

Nurse's notes dated 9/11/20 indicated Resident C1 had a fever of 100.9 in the morning. The resident had slept all evening and had a temperature of 100.9 in the evening. Resident C1 received two doses of 325mg. Acetaminophen during the morning of 9/11/20 as well as one dose of 400mg. ibuprofen. He denied any other symptoms. On 9/12/20 he was noted to have a slightly elevated temperature of 100.9. Resident C1 was given Tylenol and ibuprofen and his fever went down to 98.7. He denied pain and shortness of breath. On 9/13/20, Resident C1 was noted to be alert and oriented. He had a low grade fever at 6:30 AM of 100.3. Ibuprofen was given and his temperature went down to 98.7 at 10:00 AM. He denied any other complaints. At 12:00 AM on 9/14/20, a Residential Aide noted Resident C1 was awake and using the bathroom. At 2:00 AM, when the Residential Aide went to check on him he was unable to be roused. The Aide called 911 and began CPR. Resident C1

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R 374	Continued From page 7 was declared deceased by the paramedic according to the note and transferred to a local funeral home. Resident C1's cause of death was listed as Arteriosclerotic Cardiovascular Disease. There was no indication the resident's doctor was not notified as indicated in the policy. On 10/13/20 at 9:10 AM the DON reported she had not contacted Resident C-1's doctor regarding his low grade fever. She stated it was not necessary to contact the doctor for a low grade fever. They were unaware of anyone in the building having COVID 19 in the building at that time. The Administrator confirmed these findings on 10/26/20 at 11:40 AM	R 374		
R 582	481-57.16(3) Medical Examinations 481-57.16(135C) Medical examinations. 57.16(3) The person in charge shall immediately notify the primary care provider of any accident, injury or adverse change in the resident's condition that has the potential for requiring physician intervention. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to immediately notify the primary care provider of change of condition for 1 of 5 former residents reviewed (Resident C1). Findings follow: On 10/12/20 review of Resident C1's face sheet	R 582	Corrected In the event that a resident has an "adverse change in condition" the PCP will be notified, such as for an abnormal blood pressure reading. The PCP does not require Mediapolis Care to notify them when a resident has a low-grade fever and has ordered PRN medication to be given to the resident if they are to run a temperature. All staff members will be educated regarding such. The DON will monitor & oversee all medications & treatments.	1/7/2021

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R 582	Continued From page 8	R 582		

revealed he was admitted to the facility on 3/8/07 with diagnoses including Hypertension, Asthma, Diabetes Mellitus Type II and Hypercholesterolemia. According to his Physician's Orders signed on 8/21/20, he was to follow a low fat and low cholesterol diet. Resident C-1 was to have his vital signs checked once a week.

A review of Resident C1's August 2020 Medication Administration Record (MAR) revealed his blood pressure was checked twice daily. Evening blood pressure readings throughout the month of August ranged from a high of 188/92 to a low of 120/90.

A review of Resident C1's MAR dated 9/4/20 - 9/12/20 revealed evening blood pressure readings of the following (some dates had no readings): 9/4/20 - 138/62; 9/5/20 - 139/60; 9/8/20 - 108/60; 9/9/20 - 136/72; 9/10/20 - 102/72; 9/11/20 - 102/68; 9/12/20 - 82/72.

Nurse's Notes dated 9/10/20 revealed Resident C1 had been very tired recently and did not participate in group. On 9/11/20, the resident had a fever of 100.9 in the morning. He stayed in his room all day. He was noted to have slept all evening and had a temperature of 100.9 in the evening. Resident C1 received two doses of 325mg. Acetaminophen on the morning of 9/11/20 as well as one dose of 400mg. Ibuprofen. He denied any other symptoms. On 9/12/20 he was noted to have a slightly elevated temperature of 100.9. Resident C1 was given Tylenol and Ibuprofen and his fever went down to 98.7. He denied pain and shortness of breath. On 9/13/20, Resident C1 was noted to be alert and oriented. He had a low grade fever at 6:30 AM of 100.3. Ibuprofen was given and his temperature went

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R 582	Continued From page 9 down to 98.7 at 10:00 AM. He denied any other complaints. At 12:00 AM on 1/14/20, a Residential Aide noted Resident C1 was awake to use the restroom. At 2:00 AM, when the Residential Aide went to check on him he was unable to be roused. The Aide called 911 and began CPR. Resident C1 was declared deceased by the paramedic according to the note and transferred to a local funeral home. Resident C1's death certificate lists his cause of death as Arteriosclerotic Cardiovascular Disease. The Admin/Med Aide, RN/DON and Director/Owner stated on 10/13/20 at 2:25 PM they did not contact Resident C1's primary care provider about his symptoms because he only had a low grade fever and his blood pressure was known to drop.	R 582		
R 642	481-57.17(3)e Records 481-57.17(135C) Records. 57.17(3) Incident record. e. An incident report shall be completed for every accident, incident or unusual occurrence within the facility or on the premises that affects a resident, visitor, or employee. (II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete an incident report for every unusual occurrence for 2 of 5 residents reviewed (Residents #4 and #5). Findings follow:	R 642	Corrected In the event that an elopement of a resident occurs, an Incident Report will be completed and submitted to the Department of Inspections and Appeals within the required timelines. An elopement is defined as "when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff. All Staff will be educated on the correct definition of "elopement" to further reduce inaccurate reports of occurrences that are not actual elopements. Previous staff members that used the term "elopement" inappropriately are no longer employed by Mediapolis Care. The Administrator &/or Program Director will monitor oversee as they occur. Connie Schwartz 1/7/2021	1/7/2021

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R 642	Continued From page 10	R 642		

1. Review of Nurse's Notes on 10/8/20 revealed Resident #4 left the facility after supper on 4/7/20 for approximately one and a half hours. Staff A drove around looking for Resident #4 and finally found her sitting on a bench by the highway. Resident #4 was brought back to the facility. A Nurse's Note dated 6/22/20 identified Resident #4 wrote "Die" on her bilateral arms. Medication was given to Resident #4 and she was placed on suicide watch. Later in the afternoon, she eloped but was found and returned by staff without anyone needing to call the sheriff. There were no incident reports documenting either event.

2. On 10/8/20 a review of Nurse's Notes for Resident #5 revealed on 4/15/20, the resident asked the staff person who transported her to the facility to stop for a bathroom break and she attempted to run. On 4/16/20, she walked out the front door and staff chased her. She was found several blocks away hiding behind a dumpster at Casey's General Store. Later in the night, Resident #5 set off door alarms trying to leave the facility in the middle of the night. Resident #5 left the facility around 5:45 PM on 5/25/20 and was found on the side of Highway 61 running towards a van. She was brought back to the facility at 6:30 PM. On 6/8/20, a Nurse's Note documented Resident #5 went out the front door at 1:45 AM and the door alarm was activated. The Night Shift employee was unable to see which direction Resident #5 ran and did not contact the sheriff. However, Resident #5 was picked up by an on-duty officer and returned to the facility. A Comprehensive Overview of Residential Stay dated 6/25/20 noted Resident #5's last significant elopement requiring a missing person's report was 6/19/20 when she was found walking in a field on the south end of town. A Nurse's Note dated 8/28/20 identified Resident #5 was required

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R 642	Continued From page 11 to stay in her bedroom or the dining room after running away last night. After she ate dinner that night, she got up to use the restroom and eloped. On 9/13/20, a Nurse's Note identified she eloped and was brought home by Administration. There were no incident reports documenting these events. 3. The Administrator confirmed these findings on 10/26/20 at 11:40 AM.	R 642		
R 830	481-57.22(3)a Orientation and Service Plan 57.22(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) a. The service plan shall include measurable goals and objectives and the specific service(s) to be provided to achieve the goals. Each goal shall include the date of initiation and anticipated duration of service(s). Any restriction of rights shall be included in the service plan. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	R 830		

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R 830	Continued From page 12 failed to include rights restrictions in the Individual Person-Centered Service Plans of 2 of 5 residents reviewed (Residents #4 and #5). Findings follow: 1. An interview with the LPN (Licensed Practical Nurse) on 10/8/20 at 1:50 PM revealed she was aware Resident #4 had a plus and minus system the resident developed related to her service plan with her IHH (Integrated Home Health) worker. The LPN stated the plus/minus system could result in the loss of Resident #4's possessions, including her television. The LPN had no further details on the system and it was not referenced in the service plan. On 10/13/20 at 12:45 PM Staff B stated Resident #4 got her cell phone one hour per day. She believed this was because Resident #4 called her parents all of the time if she had it longer. On 10/13/20 at 1:15 PM Staff C stated Resident #4 had her cell phone cord taken away because she tried to choke herself with it. She believed she did have access to her cell phone. On 10/13/20 at 8:10 AM Staff D reported Resident #4 was not allowed to have her phone charger or her clothing in her room because she had tied them around her neck. Staff D believed Resident #4's parents (who were not her guardians) had agreed to the restriction regarding the phone and charger. Record review on 10/8/20 revealed Resident #4 had an Individual Person-Centered Service Plan dated 11/1/19 - 10/31/20. According to the plan, Resident #4 had the following restrictions identified: her medications were kept locked and she had a mental health commitment. Her plan	R 830	Corrected Every resident has an Individual Person-Centered Plan (IPCP). Rights and Restrictions are written into the plan and a plan to restore. Staff will meet with the interdisciplinary team including the resident and the resident's responsible party (if applicable), and discuss further in detail each and every concern that may need to be a rights restriction. If it is deemed appropriate by the team, the plan will be written with the explanation and details of each right restriction. It will be reviewed quarterly and more if necessary. It will be documented in the plan and staff will be more clearly informed and educated of such. If it renders a PCP order, a PCP order will be sought and if agreed upon it will be in the plan and duly noted as such. ★ Additionally, if a resident has a change in condition or needs, the service plan and or goals will be updated accordingly within five (5) working days. Changes will be conveyed to all individuals who work with the resident. The Program Director will monitor + oversee Resident Individual Person-Centered Plans/goals/Rights Restrictions	1/7/21

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R 830	Continued From page 13 stated all restrictions would be reviewed quarterly. The plan contained no information regarding the removal of possessions due to behaviors. 2. A Comprehensive Overview of Residential Stay report for Resident #5 identified she was a consistent elopement risk since admission. Her efforts were contrived and calculated, intentionally slipping out unnoticed. Efforts to reduce the activity by confiscating her shoes when not needed had failed. That comment was repeated in the 6/18/20 and 6/25/20 overviews. Resident #5 had an Individual Person-Centered Service Plan dated 4/15/20-4/14/21. Identified Right's Restrictions were the need for payee, medications were locked up for her safety and she had a mental health commitment. Her plan stated all restrictions would be reviewed quarterly. There was no mention of removal of shoes in an attempt to eliminate elopements. 3. The Administrator, Director of Nursing, and Program Director reported they had removed things such as cords and pants from Resident #4's room due to her attempts to harm herself. They had also removed her phone due to her calling people all of the time. In addition, Resident #5's shoes had been taken from her to try and stop her from leaving the facility, but it did not produce the results they wanted. They confirmed these restrictions were not in the residents' service plans on 10/13/20 at 2:25 PM.	R 830		
R 834	481-57.22(3)c Orientation and Service Plan 57.22(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the	R 834		

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R 834	Continued From page 14 resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to update the service plan as needs changed for 1 of 5 residents reviewed (Resident #5). Findings follow: Record review on 10/13/20 revealed a Comprehensive Overview of Nurse's Notes dated 5/5/20 documented Resident #5 had been a consistent elopement risk since admission. It noted her efforts were consistently calculated and planned, not the result of angry or frustrated outbursts. On 4/15/20, Resident #5 asked the	R 834	★ Please see R830	

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R 834	Continued From page 15	R 834		

staff person who brought her to the facility to stop for a bathroom break and she attempted to run. On 4/16/20, she walked out the front door and staff chased her. She was found several blocks away hiding behind a dumpster at Casey's General Store. Later in the night, Resident #5 set off door alarms trying to leave the facility in the middle of the night. On 4/17/20 and 4/18/20, Resident #5 walked out the front door but staff followed her and caught up to her immediately. On 4/30/20, Resident #5 sat in the dining room all day observed by staff and the RN (Registered Nurse) sitting at the nurse's station. Resident #5 left the dining room as soon as the RN left and other staff were summoned to another room. A missing person's report was called to the Sheriff's Department. Resident #5 was found running along Highway 61 South and returned to the facility with staff. Nurse's Notes revealed on 4/20/20 Resident #5 took off down the street and staff followed her and were able to bring her back. On 5/12/20, Resident #5 left the facility according to a Nurse's Note but was caught by staff before getting too far. Resident #5 left the facility around 5:45 PM on 5/25/20 and was found on the side of Highway 61 running towards a van. She was brought back to the facility at 6:30 PM. Nurse's Note's indicated Resident #5 left the facility at 1:30 PM on 5/29/20 and a missing person's report was completed. She returned to the facility at 5:30 PM. On 6/8/20, a Nurse's Note documented Resident #5 went out the front door at 1:45 AM and the door alarm was activated. The Night Shift employee was unable to see which direction Resident #5 ran and did not contact the sheriff, however she was picked up by an on-duty officer and returned to the facility. A Comprehensive Overview of Residential Stay form dated 6/25/20 noted Resident #5's last significant elopement requiring a missing

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R 834	Continued From page 16	R 834		

person's report was 6/19/20 when she was found walking in a field on the south end of town. It identified Resident #5 had been a consistent elopement risk since admission and efforts to reduce the activity by confiscating her shoes had failed. An Incident/Accident Reporting Form dated 7/17/20 identified Resident #5 went out the front door and began to run down the street and staff followed the member. Resident #5 then got into a vehicle which drove towards Burlington. Staff followed the vehicle. The member was let out of the vehicle in Burlington. The member ran into highway traffic again when she saw the staff person who had been following her. The staff person was able to get Resident #5 to return to the facility with them. A Nurse's Note dated 8/28/20 identified Resident #5 was required to stay in her bedroom or the dining room after running away last night. After she ate dinner that night, she got up to use the restroom and eloped. On 9/13/20, a Nurse's Note identified she eloped and was brought home by Administration.

A Monthly-Quarterly Progress Report dated 6/30/20 noted Resident #5 had made very little progress since her admission. It added she continued to be an elopement risk. She had attempted to elope many times recently but had been redirected by staff. She had attempted to crawl out of the living room window in hopes of eloping.

Record review on 10/13/20 revealed Resident #5 had an Individual Person-Centered Service Plan dated 4/15/20. Resident #5 was admitted to the facility on 4/15/20. One of Resident #5's goals was to be able to positively cope in social situations. A second goal was to participate in activities. Barriers to success were Resident #5 becoming anxious and running away. Resident #5

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R 834	Continued From page 17 was also noted to have auditory hallucinations due to schizophrenia. It was noted in the comments section of her plan Resident #5 had a history of having the urge to walk and had left placements. She did not like to be in strange places alone and would take off if she did not see staff around. There was no specific goal or objectives in the plan to decrease elopements or attempts to run from the facility. On 10/13/20 at 2:25 PM the Administrator, Director of Nursing, and Program Director confirmed Resident #5's service plan had not been updated to address her needs as she continued to try to leave the facility	R 834		
C 147	50.7(4) Additional notification 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: 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the Department of elopements regarding 2 of 5 residents reviewed (Residents #4 and #5). Findings follow: 1. Review of Nurse's Notes on 10/8/20 revealed Resident #4 left the facility after supper on 4/7/20	C 147	Please see R 642	

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for approximately one and a half hours. Staff A drove around looking for Resident #4 and finally found her sitting on a bench by the highway. Resident #4 was brought back to the facility. Staff A talked with Resident #4 and the resident's mother over the phone. Items were removed from Resident #4's room after she lashed out due to reporting being suicidal. She later calmed down and fell asleep.

A Nurse's Note dated 6/22/20 identified Resident #4 wrote "Die" on her bilateral arms. Medication was given to Resident #4 and she was placed on suicide watch. Later in the afternoon, she eloped but was found and returned by staff without anyone needing to call the sheriff.

2. A review of Nurse's Notes for Resident #5 revealed on 4/30/20, she left the facility around 4:45 PM. Staff went looking for her and could not find her anywhere. The police were called and she was found and brought back to the facility at 6:30 PM. She took a shower, had a snack and went to bed. There was no sign she suffered any injury.

A Nurse's Note documented on 5/22/20, Resident #5 took off around 5:45 PM. She was found on the side of the highway running towards a van which was pulled over on the side of the road. Resident #5 was brought back to the facility around 6:30 PM.

According to a Nurse's Note, Resident #5 left the facility at 1:30 PM on 5/29/20. The police were called and a missing person's report was completed. Resident #5 arrived back at the facility around 5:30 PM. The Administrator and Director of Nursing talked with Resident #5 about the incident. An Incident Report was completed

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giving more information and describing the situation as an elopement. Resident #5 had been playing basketball on the patio and walked away from the facility. The Administrator signed the incident report.

A Nurse's Note dated 6/19/20 reported Resident #5 eloped that day. A missing person's report was filed. Resident #5 was found by staff and the report was canceled. A Comprehensive Overview dated 6/25/20 noted she was found walking out in a field on the south end of town.

On 8/28/20 a Nurse's Note documented Resident #5 eloped from the facility after dinner.

Resident #5 eloped from the facility on 9/13/20 according to Nurse's Notes and was brought home by administration.

3. Staff A was interviewed on 10/13/20 and reported Resident #4's mother called on 4/7/20 to notify them her daughter had left the facility. Staff A had a difficult time locating Resident #4 in the community. Staff A said she worked on an "as needed" basis, but recalled two times Resident #4 eloped from the facility. She said staff tried to keep a close eye on Resident #5. She recalled one time when Resident #5 eloped and the Sheriff had to be contacted.

When interviewed on 10/13/20 at 12:45 PM Staff B recalled one incident when she was working when Resident #4 eloped. Although oftentimes she was aware when Resident #4 left the building on her own, there was one time in late July or early August when she did not know Resident #4 left. She was later found sitting on a bench away from the property. Staff B described Resident #5 as someone who took off like a ghost. The last

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time this happened was at the end of August when Resident #5 was not in her bed when they did bed checks. Another staff member's family found Resident #5 walking down the road. Staff B believed Resident #5 had eloped 3 or 4 times times when she was working at the facility.

On 10/13/20 at 1:40 PM, the Program Director reported she could think of 2 or 3 times when Resident #5 had eloped from the facility, stating she liked to go out through the window.

Resident #4's mother was contacted on 10/12/20 at 2:40 PM. She stated she had called her daughter on 4/7/20 and her daughter said she was lost. The mother called the facility and informed them her daughter had left and where she was. Someone from the facility reportedly called her back an hour later and said they couldn't find her daughter. The mother then gave them directions again and her daughter was located.

A meeting was held with the Administrator, Director of Nursing and Program Director on 10/13/20 at 2:25 PM. They stated they did recall the incident of Resident #4's mother calling to report her daughter missing, but generally when Resident #4 left, she made a big production of leaving. They could not recall other times she had left without staff being aware of her leaving. The Administrator thought reports had been made when Resident #5 had eloped from the facility, but the Program Director confirmed they had not.

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