

**Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation**

Date:	August 2, 2018
Program Name:	Milestones Adult Day Health Center
Address:	1725 O Avenue NW Cedar Rapids, IA 52405
Type of Action:	investigation 76490-I
Date(s) of Action:	7/18/18 to 7/19/18

State Rule #	State Rule	Amount of Civil Penalty
70.26(1)	<u>481-70.26(231D) Service plans.</u> <u>70.26(1) A service plan shall be developed for each participant based on the evaluations conducted in accordance with subrules 70.22(1) and 70.22(2) and shall be designed to meet the specific service needs of the individual participant. The service plan shall subsequently be updated at least annually and whenever changes are needed.</u> Based on observation, interview and record review the Program failed to ensure specific need areas were addressed in the care plan for 1 of 1 participants reviewed who eloped from the building (Participant #1). Findings include: Review of a Participant Incident Report dated 6-4-18 at 10:10 a.m. revealed Staff A left the center for an outing and observed Participant #1 walking on the road. She called the center and reported it to Staff C. Staff C notified the Director and they both left the building to look for the participant. Staff C walked and the Director drove her car. Participant #1 was spotted a few houses away walking towards the center. Review of the Home Care Schedule Check In/Out Report revealed Participant #1 arrived at the center at 9:15 a.m. that day. The WanderGuard Bracelet Client Check In form for Participant #1 revealed her bracelet was put in place at 10:35 a.m. by Staff B. Observation revealed the Program was located in a residential area on a two lane street with a speed limit of 30 mph. Google Maps revealed the participant was .21 miles away from the center when observed. The investigation revealed the participant walked along the street and not on a sidewalk. The temperature on 6-4-18 at 10:00 a.m. was 70 degrees according to Wunderground.com. On 7-18-18 at 11:59 a.m. Staff A stated she left the premises in the van for an outing around 10:00 a.m. on 6-4-18. She stated she noticed Participant #1 walking in the road. She stopped and called the center and told Staff C that Participant #1 was outside walking back to the center. On 7-18-18 at 12:24 p.m. Staff D confirmed she greeted Participant #1 on 6-4-18 when the participant arrived and stated she was agitated and refused to wear the WanderGuard bracelet. Staff D took the participant to the dining room area and explained to Staff B she was upset and to watch her until she calmed down. Staff D stated she told Staff B that Participant #1 refused to wear her WanderGuard bracelet.	\$500.00

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	Staff D felt she was no longer responsible for Participant #1 because she left her with Staff B. She knew Participant #1 had a history of elopement when upset and stated the person assigned to the lobby area should have noticed her exiting. She stated she was not sure what to do when the participant refused to wear the WanderGuard bracelet. On 7-18-18 at 12:53 p.m. Staff B stated she did not recall the day of the elopement specifically. She stated that if Staff D brought Participant #1 to her and said she refused to wear the WanderGuard she would have attempted to put it on like she had done at other times. It was not unusual for Participant #1 to refuse to put on the bracelet when arriving at the center. On 7-18-18 at 11:35 a.m. Staff C stated she received a call from Staff A regarding Participant #1 walking on the road. She notified the Director and they both went to go look for her. Staff C walked to the road and when she came to the top of the hill she was able to see Participant #1 walking towards her a short distance away. Participant #1 was agitated and yelled at Staff C to leave her alone and get away as she continued to walk back towards the center. Staff C walked behind her until she was inside the building. Staff C stated the participant did not have her WanderGuard bracelet on but allowed one to be put on after she returned. She said Participant #1 had a history of exiting the building and required the bracelet for safety. She stated they were trained that if a person refused to wear the bracelet, another staff should try to convince the participant to wear it. If not successful, staff were to keep eyes on that person. On 7-18-18 at 11:46 a.m. the Director stated Staff C notified her about Participant #1 being seen walking down the road by another staff. The Director got in her car and Staff C walked to find her. Participant #1 was spotted a few blocks from the center walking towards the building. Staff D told her after the incident that Participant #1 refused to wear the WanderGuard bracelet when she arrived that morning. The Director stated she trained staff that the person who greeted the participant upon arrival was responsible to make sure the WanderGuard bracelet was put in place for those who required one. If the person refused to wear it then all staff were to be notified in order to keep eyes on that person at all times Record review on 7-18-18 revealed Participant #1 was admitted to the Program on 7-25-17 with diagnoses including Alzheimer's disease, major depressive disorder, and anxiety. Review of a Mini Mental State Exam dated 7-14-17 revealed she scored 13 out of 30 and scored 5 on the Global Deterioration Scale which indicated moderate cognitive impairment. Review of a Health Assessment dated 4-23-18 revealed behaviors of wandering, resisting cares, violence, anxiety and a lack of awareness of her own needs. The care plan dated 7-25-17 revealed she was a high risk for elopement and required a WanderGuard bracelet as ordered from her Primary Care Provider. The care plan did not include any information or directives for staff regarding what to do when the participant refused to wear the WanderGuard bracelet.	
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