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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had dementia, [MEDICAL CONDITION], and [MEDICAL CONDITION]. 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 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 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 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 0730 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Observe each nurse aide's job performance and give regular training.** 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. 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.