Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Number 5289	Fine amount reduced by 35% to $325.00 on December 23, 2013, pursuant to Iowa Code section 135C.43A (2013)		Report Date November 20, 2013	
Facility Name Center Village of Tenco		Survey Dates September 12, 23 & 25, 2013; & October 3, 17, 24 and 25, 2013		
Facility Address 19248 Maple Ave.	Surveyor(s) Brian Imhoff, QIDP			
City Keosauqua, IA. 52565	HL			

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
57.25(3)e	**57.25(3)** *Resident safety.* *e.* Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. (II, III) **DESCRIPTION:** Based on interview and record review the facility failed to ensure all residents consistently received the appropriate level of supervision. This affected 3 of 7 residents reviewed. Findings follow: 1. Record review on 9/23/13 of Resident #1's chart revealed an incident report dated 8/1/13 which documented that a wire cutter and a utility knife were found in the resident's bedroom. The items were found by staff when they searched Resident #1's room. The rights restrictions revealed Resident #1 was not allowed to have weapons or knives at the RCF (residential care center) due to terms of his/her probation. During an interview on 10/3/13 at 3:30 p.m. the resident reported getting the wire cutter and utility knife out of a tool shed on the facility grounds. The resident reported the tool shed was unlocked and not supervised by staff. 2. Record review on 10/17/13 of Resident #2's chart revealed the following: - The resident had a diagnoses of alcohol induced dementia and depression. - An incident report dated 5/5/13 which outlined Resident #2 engaging in what appeared to be intoxicated behavior (slurred speech and a unsteady gait). When staff intervened the resident reported consuming gasoline and dandelions. The staff contacted poison control and the emergency room. The staff attempted to send Resident #2 to the emergency room, but he/she refused. The staff then	II	$500.00	Upon Receipt

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Facility Administrator _____ Date _____

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	contacted the hospital and had an ambulance come to evaluate the resident. Resident #2's vitals were taken and he/she appeared normal. Staff provided 1:1 supervision through the night. - An incident report dated 7/18/13 which outlined Resident #2 engaging in verbally aggressive behavior. - An incident report dated 8/12/13 which outlined the Activity Coordinator leaving Resident #2 unattended/unsupervised during a community outing. Resident #2 walked across the street and purchased two bottles of alcohol. Resident #2 did not consume the alcohol. The report documented staff would supervise Resident #2 when shopping in the community. During an interview on 10/17/13 at 1:00 p.m., Resident #2 reported feeling depressed on 5/5/13 and taking a small drink of lawn mower gasoline which was left unlocked in one of the buildings on grounds. The resident reported forcing him/her(self) to vomit immediately afterwards. The resident stated minimal gasoline was ingested and no medical attention was needed. Resident #2 reported finding a bottle of alcohol in the ditch between the facility and a nearby recycling center while on a walk on 7/18/13. The resident reported drinking about half the bottle and returning to the facility. The resident admitted getting into an argument with some younger male residents after returning to the facility. Resident #2 also reported going on a community outing around 8/12/13. During this outing the Activity Coordinator went into a store with another resident. The resident remained alone outside the store for several minutes before deciding to go across the street to buy a bottle of alcohol at a convenience store. An off duty staff saw the resident purchase the alcohol and made the resident return it before any alcohol was consumed. 3. During an interview on 10/17/13 at 1:40 p.m., Resident #3 stated he/she had gone to a demolition derby sometime in July with staff and other residents. He/she			

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	became annoyed with the noise level and decided to walk back to the facility. He/she did not tell staff about leaving because he/she thought they would tell him/her to stay or they would have to transport all the residents back to the facility. The resident walked about 10 minutes before being picked up by staff. He/she reported being in good physical health and able to walk long distances. A review of the resident's file revealed an incident report dated 7/27/13. The report revealed staff realized at 6:30 p.m. that Resident #3 was no longer with them at the fairgrounds. Staff looked all around the fairgrounds, then drove up and down the road until the resident was found at 7:00 p.m. At that time the resident chose not to get in the van but wanted to walk to the facility. Staff followed him/her back to the facility. The staff in charge of the outing was the Activity Coordinator. Resident #3's case management support services form identified he/she had previously accessed the community independently and had a driver's licenses. While at the RCF Resident #3 should rely on staff for all transportation. Resident #3 had a history of hitchhiking or going on drives and staff needs to monitor him/her when in the community. During an interview with the Administrator on 10/17/13 at 1:30 p.m., it was reported the facility took corrective action in terminating the Activity Coordinator for failure to provide adequate resident supervision during outings. All buildings on grounds that contain any hazards or dangerous chemicals are now locked at all times when not being directly supervised by staff. F**ACILITY RESPONSE:**			

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