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
	690403	A. BUILDING: _____ B. WING _____	C 10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER VILLAGE OF TENCO	19248 MAPLE AVENUE KEOSAUQUA, IA 52565

(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 No deficiencies were cited as a result of investigation #45280-C. The following deficiencies were cited as a result of investigations #44988-C and #44933-C.	R 000	DD 12/11/13	
R 378	57.25(3)e Safety 481--57.25(135C) Safety. The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. 57. 25(3) Resident safety. e. Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. This REQUIREMENT is not met as evidenced by: 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	R 376		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	890403	A. BUILDING: _____ B. WING _____	C 10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER VILLAGE OF TENCO	19248 MAPLE AVENUE KEOSAUQUA, IA 52585

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R 378	Continued From page 1 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 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	R 378		

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R 378	Continued From page 2	R 378		

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 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

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R 378	Continued From page 3 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.	R 378		
R 549	57.36(1)l Involuntary discharge or transfer 481-57.36(135C) Involuntary discharge or transfer. 57.36(1) A facility shall not involuntarily discharge or transfer a resident from a facility except: For medical reasons; for the resident's welfare or that of other residents; for nonpayment for the resident's stay (as contained in the contract for the resident's stay), except as prohibited by Title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396k and by reason of action pursuant to	R 549		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN DF CDRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	890403	A. BUILDING: _____ B. WING _____	C 10/25/2013

NAME DF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER VILLAGE OF TENCO	19248 MAPLE AVENUE KEOSAUQUA, IA 52565

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R 549	Continued From page 4 chapter 229, The Code. I. The resident shall receive counseling services before (by the sending facility) and after (by the receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident's record. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure counseling services were provided for 1 of 1 residents reviewed who was involuntarily discharged (Resident #1). Findings follow: Record review on 9/23/13 revealed Resident #1 was involuntarily discharged on 8/13/13 due to engaging in a variety of disruptive behaviors. Further record review failed to reveal any documentation indicating any type of counseling services were provided for the resident after the facility administration made the decision to discharge the resident. During an interview on 10/3/13 at 3:30 p.m., Resident #1 confirmed receiving no counseling prior to being discharged and no prior notification that he/she was being involuntarily discharged. The resident reported being unaware of the discharge until law enforcement arrived at the facility to transport the resident to jail. During an interview on 10/17/13 at 1:30 p.m., the Administrator stated that multiple meetings were held with Resident #1 to clarify the facility rules. During each meeting it was communicated to the resident that continued rule violations would result in discharge from the facility. The Administrator	R 549		

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R 549	Continued From page 5 confirmed no discharge counseling was provided for the resident after the decision was made to discharge the resident. During an interview on 10/25/13 at 9:30 p.m. the Probation Officer for Resident #1 reported getting a phone call from the facility on 8/13/13 informing her that Resident #1 was being discharged from the facility due to additional rule violations. Resident #1 was then placed in county jail due to no other options being available under short notice.	R 549		

12/3/13

PLAN OF CORRECTION

Provider/Supplier Name:	Center Village of Tenco
Street Address, City, Zip:	19248 Maple Avenue
Date of Survey:	October 25, 2013

PROVIDER/SUPPLIER/CLIA IDENTIFICATIDN NUMBER	890403

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
R000	No deficiencies were cited as a result of investigation #45280-C	NA
R378	57.25(3) e Safety 481--57.25 (135C) Safety. The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. 57. 25(3) Resident safety. e. Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. ***Center Village of Tenco will follow guidelines in regards to resident safety section 57.25(3) by praviding residents with adequate supervision to ensure against hazard from themselves, others, ar elements in the environment.*** ***Residents are not allowed access ta harmful items; All buildings an the grounds being used as starage areas for harmful items are kept locked at all times; Residents will be supervised on autings as outlined in Tenco Industries palicies and procedures manual. Adequate staffing will be utilized to assist the Activity Coardinatar with cammunity outings. All staff members will be arientated an resident's goals and right restrictions within 10 days of his/her start date in order to better understand haw ta better serve residents.***	Effective Immediately
R549	57.36(1)l Involuntary discharge or transfer 481-57.36(135C) Involuntary discharge or transfer 57.36(1) A facility shall not involuntarily discharge or transfer a resident from a facility except: For medical reasons; for the resident's welfare or that of other residents; for nonpayment for the resident's stay (as contained in the contract for the resident's stay), except as prohibited by Title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396k and by reason of action pursuant to chapter 229, The Code. l. The resident shall receive counseling services before (by the sending	Effective Immediately

Per Correspondence with Administrator, She will be in Charge of ensuring Compliance.

12/1/13

	facility) and after (by the receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident's record. ***Center Village of Tenco will follow all discharge or transfer rules as outlined in 57.36(1) Including but not limited to the resident receiving counseling services before (by the sending facility) and after (by the receiving facility) the involuntary transfer to minimize possible adverse effects of the involuntary transfer. Counselling shall be documented in the resident's records.***	