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
	170501	A. BUILDING: _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH IOWA TRANSITION CENTER	408 FIRST STREET NW MASON CITY, IA 50401

(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
C 000	01 Initial Comments The following deficiencies were cited during the survey conducted to determine if the facility remained in substantial compliance with licensing rules for a Residential Care Facility for Persons with Mental Illness.	C 000		
C 215	01-50.9(8)a(2) Background Checks 481-50.9(135C) Criminal, dependent adult abuse, and child abuse record checks. 50.9(8) Change of employment-person with criminal or abuse record-exception to record check evaluation requirements. A person with a criminal or abuse record who is or was employed by a facility and is hired by another facility shall be subject to the background check. a. A reevaluation of the latest record check is not required, and the person may commence employment with the other facility if the following requirements are met: (2)The latest background check does not indicate a crime was committed or founded abuse record was entered subsequent to the previous evaluation; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility hired Staff B before obtaining an evaluation from the Department of Human Services (DHS) regarding additional criminal charges incurred since the last DHS evaluation was completed. Findings include: Record review on 12/3/13 of Staff B's personnel	C 215		

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

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C 215	Continued From page 1 record revealed the facility completed the abuse and criminal history checks using the "Single Contact License and Background Check" system on 5/6/13. The results indicated Staff B had a criminal history. Staff B's record indicated various charges dating from 2009 to 2012. Staff B had a previous letter from DHS which approved her/him to work in a licensed health care facility dated 8/6/10. Staff B was hired by the facility on 5/13/13. After employment the facility submitted a request to DHS for Staff B's additional criminal charges to be evaluated. The facility received notice on 5/23/13 that the staff was approved to work at their agency. Interview with Staff D on 12/3/13 at 10:30 am revealed the facility believed Staff B had already been approved to work at a licensed health care facility prior to his/her hire date, thus they hired Staff B on 5/13/13 prior to the second evaluation conducted by DHS on 5/23/13.	C 215		
I 179	62.9(1)f(1) Personnel 481--62.9(135C) Personnel. 62.9(1) The personnel policies and procedures shall include the following requirements: f. A plan for a continuing education program with a minimum of eight in-service programs per year for all employees which shall include a written, individualized staff development plan for each employee. This includes, but is not limited to, the administrator, department heads, and direct care staff. The plan shall take into consideration the needs of the facility as identified in the resume of care. The plan shall ensure that each employee has the opportunity to develop and enhance skills	I 179		

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I 179	Continued From page 2 and to broaden and increase knowledge contributing to effective resident care, including but not limited to: (1) First aid. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 2 staff employed by the facility for over 12 months had received training in first aid during the past year (Staff E). Findings include: Record review on 12/3/13 of employee files revealed Staff E had a hire date of 10/6/94. A review of staff in-service records for the past 18 months revealed no documentation the staff had received first aid training in the past year. Interview with Staff A and Staff D at the time of the finding confirmed the above.	I 179		
I 180	62.9(1)f(2) Personnel 481--62.9(135C) Personnel. 62.9(1) The personnel policies and procedures shall include the following requirements: f. A plan for a continuing education program with a minimum of eight in-service programs per year for all employees which shall include a written,	I 180		

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I 180	Continued From page 3 individualized staff development plan for each employee. This includes, but is not limited to, the administrator, department heads, and direct care staff. The plan shall take into consideration the needs of the facility as identified in the resume of care. The plan shall ensure that each employee has the opportunity to develop and enhance skills and to broaden and increase knowledge contributing to effective resident care, including but not limited to: (2) Human needs and behavior. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 2 of 2 staff employed by the facility for over 12 months had received training in human needs and behavior during the past year (Staff D and E). Findings include: Record review on 12/3/13 of employee files revealed Staff D had a hire date of 7/30/12 and Staff E had a hire date of 10/6/94. A review of staff in-service records over the past 18 months revealed no documentation that either staff had received training in human needs and behavior in the past year. Interview with Staff A and Staff D at the time of the finding confirmed the above.	I 180		
I 181	62.9(1)f(3) Personnel	I 181		

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I 181	Continued From page 4 481--62.9(135C) Personnel. 62.9(1) The personnel policies and procedures shall include the following requirements: f. A plan for a continuing education program with a minimum of eight in-service programs per year for all employees which shall include a written, individualized staff development plan for each employee. This includes, but is not limited to, the administrator, department heads, and direct care staff. The plan shall take into consideration the needs of the facility as identified in the resume of care. The plan shall ensure that each employee has the opportunity to develop and enhance skills and to broaden and increase knowledge contributing to effective resident care, including but not limited to: (3) Problems and needs of persons with mental illness. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 2 of 2 staff employed by the facility for over 12 months had received training in problems and needs of persons with mental illness during the past year (Staff D and E). Findings include: Record review on 12/3/13 of employee files revealed Staff D had a hire date of 7/30/12 and Staff E had a hire date of 10/6/94. A review of staff in-service records over the past 18 months	I 181		

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I 181	Continued From page 5 revealed no documentation that either staff had received training in problems and needs of persons with mental illness in the past year. Interview with Staff A and Staff D at the time of the finding confirmed the above.	I 181		
I 182	62.9(1)f(4) Personnel 481--62.9(135C) Personnel. 62.9(1) The personnel policies and procedures shall include the following requirements: f. A plan for a continuing education program with a minimum of eight in-service programs per year for all employees which shall include a written, individualized staff development plan for each employee. This includes, but is not limited to, the administrator, department heads, and direct care staff. The plan shall take into consideration the needs of the facility as identified in the resume of care. The plan shall ensure that each employee has the opportunity to develop and enhance skills and to broaden and increase knowledge contributing to effective resident care, including but not limited to: (4) Medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 2 of 2 staff employed by the	I 182		

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I 182	Continued From page 6 facility for over 12 months had received training regarding medications during the past year (Staff D and E). Findings include: Record review on 12/3/13 of employee files revealed Staff D had a hire date of 7/30/12 and Staff E had a hire date of 10/6/94. A review of staff in-service records over the past 18 months revealed no documentation that either staff had received training regarding medications in the past year. Interview with Staff A and Staff D at the time of the finding confirmed the above.	I 182		
I 186	62.9(1)f(8) Personnel 481--62.9(135C) Personnel. 62.9(1) The personnel policies and procedures shall include the following requirements: f. A plan for a continuing education program with a minimum of eight in-service programs per year for all employees which shall include a written, individualized staff development plan for each employee. This includes, but is not limited to, the administrator, department heads, and direct care staff. The plan shall take into consideration the needs of the facility as identified in the resume of care. The plan shall ensure that each employee has the opportunity to develop and enhance skills and to broaden and increase knowledge contributing to effective resident care, including but not limited to: (8) Fire safety, disaster, and tornado preparation.	I 186		

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I 186	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 2 of 2 staff employed by the facility for over 12 months had received training in fire safety, disaster, and tornado preparation during the past year (Staff D and E). Findings include: Record review on 12/3/13 of employee files revealed Staff D had a hire date of 7/30/12 and Staff E had a hire date of 10/6/94. A review of staff in-service records over the past 18 months revealed no documentation that either staff had received training in fire safety, disaster and tornado preparation in the past year. Interview with Staff A and Staff D at the time of the finding confirmed the above.	I 186		
I 224	62.9(5) Personnel 481-62.9(135C) Personnel. 62.9(5) Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse. The facility shall comply with the requirements found in Iowa Code section 135C.33 as amended by 2013 Iowa Acts, Senate File 347, and rule 481-50.9(135C) related to completion of criminal record checks, child abuse checks, and dependent adult abuse checks and to employment of individuals who have committed a	I 224		

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I 224	Continued From page 8 crime or have a founded abuse. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to comply with requirements related to employee background checks found in Iowa Administrative Code 481 - chapter 50. Findings include: A review of employee files revealed the facility failed to have the Department of Human Services evaluate a prospective employee's criminal record prior to hire as required by Iowa Administrative Code rule 481-50.9(8)a(2).	I 224		
I 231	62.11(1) Evaluation services 481-62.11(135C) Evaluation services. 62.11(1) Each resident admitted shall have had a physical examination prior to admission and annually thereafter. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed had obtained a physical prior to admission (Resident #3). Finding includes: Record review on 12/3/13 of Resident #3's file revealed the resident was admitted on 8/1/13. Further review of the file failed to reveal an	I 231		

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I 231	Continued From page 9 admission physical. The resident did have a physical completed on 11/8/13 which was well after admission. Interview with the facility LPN (Staff F) at the time of the finding confirmed a pre-admission physical could not be located.	I 231		
I 341	62.15(1)b Medication management 481-62.15(135C) Medication management. 62.15(1) Medications shall be prescribed on an individual basis by one who is authorized by Iowa law to prescribe. b. Qualified staff shall ensure that residents are able to take their own medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to have qualified staff ensure residents were capable of administering their own medications. This affected residents #1, #3, #4 and #5. Findings include: Observation of medication administration on 12/3/13 and 12/4/13 revealed the following: a.) Resident #4 unlocked his/her medication box on 12/3/13 at 1:10 pm. The resident was unable to tell the Surveyor what medication he/she was taking or what the date was. After taking the medication Vistaril 50 mg 1 tablet, Resident #4 went to fill out his/her Medication Administration Record (MAR) and signed the wrong date. When the Resident was told what the correct	I 341		

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I 341	Continued From page 10	I 341		

date was he/she then signed the correct date but for the wrong medication. It was also noted the resident's MAR had several blanks from the previous day.

b.) Resident #5 unlocked his/her medication box on 12/4/13 at 7:25 am and seemed knowledgeable about the medications he/she was taking. The resident then went to fill out their MAR and signed the wrong date. The resident was a day off and had filled in the medication for the day before for Amplipine 5 mg and Sulcarfate 1000 mg.

Record review on 12/3/13 of revealed the following:

a.) Resident #3 had an Incident Report dated 11/3/13 which described how the resident had taken 4 tablets of Noproxen 500 mg the night before thinking it would help him/her sleep. The resident was then taken in to see his/her mental health provider. In addition Resident #3 had a Physician Consult dated 11/4/13 that described how the resident had refused to take nighttime medications for 4 straight days. Labs were ordered.

b.) Resident #1 had an Incident Report dated 10/28/13 which described how the resident had asked staff for a sleeping pill at 5 am even though it was almost time to get-up for the day. The staff noted the resident was out of sleeping pills and had not taken his/her AM medications for 1 week. In addition Resident #1's Social History dated 10/11/13 reported the resident did not see the need for taking his/her medication and had a history of medication non-compliance. The Resident also had diagnoses which included Polysubstance Abuse.

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I 341	Continued From page 11 Interview with the LPN on 12/4/13 after the morning medication pass revealed all the residents were certified by a physician upon admission as capable of self-administering medications although it was quite evident from observation and record review some of the residents were still in need of training and monitoring due to the concerns noted above. The LPN was asked for any documentation related to ongoing medication training or monitoring and none was provided.	I 341		
I 361	62.15(2)k(1) Medication management 481-62.15(135C) Medication management. 62.15(2) Drug administration. k. Residents certified by their physician as capable of injecting their own insulin may do so. Insulin may be administered pursuant to "j" above or as otherwise authorized by the resident's physician. Authorization by the physician shall: (1) Be in writing, This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to obtain a physician order certifying Resident #2 was capable of injecting her/his own insulin. Finding includes: Observation on 12/4/13 at 7:15 am revealed Resident #2 tested her/his own blood sugar level and then self-administered 10 Units of Novolog/Insulin.	I 361		

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I 361	Continued From page 12 Record review on 12/3/13 revealed Resident #2 was an insulin dependant diabetic. The resident required an insulin injection daily. Interview with Staff A and Staff F throughout the survey confirmed Resident #2 self-administered her/his own insulin injection. Further interview with Staff F on 12/3/13 confirmed a physician order was not in place certifying Resident #2 as capable of self-administering insulin.	I 361		
I 374	62.15(4) Medication management 481-62.15(135C) Medication management. 62.15(4) Medication counseling shall be provided for all residents in accordance with the IPP on an ongoing basis and as part of discharge planning unless contraindicated in writing by the physician with reasons and pursuant to 62.12(2) " c. " Each resident shall be given verbal and written information about all medications the resident is currently using, including over-the-counter medications. A suggested reference is " USPDI, Advice for the Patient. " This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide counseling as part of the Individual Program Plan (IPP) for residents who had demonstrated concerns with administering/managing their own medications. This affected residents #1, #3, #4 and #5. Findings include:	I 374		

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I 374	Continued From page 13 Observation of medication administration on 12/3/13 and 12/4/13 revealed the following: a.) Resident #4 unlocked his/her medication box on 12/3/13 at 1:10 pm. The resident was unable to tell the Surveyor what medication he/she was taking or what the date was. After taking the medication Vistaril 50 mg 1 tablet, Resident #4 went to fill out his/her Medication Administration Record (MAR) and signed the wrong date. When the Resident was told what the correct date was he/she then signed the correct date but for the wrong medication. It was also noted the resident's MAR had several blanks from the previous day. b.) Resident #5 unlocked his/her medication box on 12/4/13 at 7:25 am and seemed knowledgeable about the medications he/she was taking. The resident then went to fill out their MAR and signed the wrong date. The resident was a day off and had filled in the medication for the day before for Amplipine 5 mg and Sulcarfate 1000 mg. Record review on 12/3/13 of revealed the following: a.) Resident #3 had an Incident Report dated 11/3/13 which described how the resident had taken 4 tablets of Noproxen 500 mg the night before thinking it would help him/her sleep. The resident was then taken in to see his/her mental health provider. In addition Resident #3 had a Physician Consult dated 11/4/13 that described how the resident had refused to take nighttime medications for 4 straight days. Labs were ordered. b.) Resident #1 had an Incident Report dated	I 374		

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I 374	Continued From page 14 10/28/13 which described how the resident had asked staff for a sleeping pill at 5 am even though it was almost time to get-up for the day. The staff noted the resident was out of sleeping pills and had not taken his/her AM medications for 1 week. In addition Resident #1's Social History dated 10/11/13 reported the resident did not see the need for taking his/her medication and had a history of medication non-compliance. The Resident also had diagnoses which included Polysubstance Abuse. The IPP's for all four residents failed to include any mention of medication programming or counseling. Interview with the LPN and facility Administrator on 12/4/13 prior to exit revealed all the residents were certified by a physician upon admission as capable of self-administering medications although it was quite evident from observation and record review some of the residents were still in need of training and monitoring due to the concerns noted above. The LPN was asked for any documentation related to ongoing medication training, programming or monitoring and none was provided.	I 374		
I 390	62.15(5)b(8) Medication management 481-62.15(135C) Medication management. 62.15(5) Drug storage. b. Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:	I 390		

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
	170501	A. BUILDING: _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH IOWA TRANSITION CENTER	408 FIRST STREET NW MASON CITY, IA 50401

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I 39D	Continued From page 15 (8) Inspection of the condition of stored drugs shall be made by the administrator and a licensed pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but need not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current order, and drugs improperly stored. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have the resident's medication storage inspected by a pharmacist at least quarterly. This affected 12 of 12 residents. Finding includes: Record review on 12/3/13 of quarterly pharmacist inspection reports revealed the following: a.) In 2013 two reports had been completed (9/12/13 and 5/20/13). b.) In 2012 two reports had also been completed (11/26/12 and 7/13/12). c.) In 2011 three reports had been completed (12/7/11, 9/23/11 and 5/23/11). Interview with the Staff A on 12/3/13 at the time of the finding confirmed no additional pharmacy inspection reports were available for review, thus the facility was missing approximately 5 inspection reports over the prior three years.	I 390		

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
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I 566	Continued From page 16	I 566		
I 566	62.21(1)a Physical facilities and maintenance 481--62.21(135C) Physical facilities and maintenance. 62.21(1) Housekeeping. The facility shall have written procedures for daily and weekly cleaning to include but need not be limited to: a. All rooms including furnishings, all corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment or accumulations of refuse. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain all areas of the facility in a clean, orderly condition. Findings include: Observations made during an environmental tour on 12/2/13 from 2:15 pm to 3:10 pm revealed the following: Rooms #2, 9 and 10 were examples of bedrooms that had clothing and personal items that were disorganized. Clothing was laying in piles making it hard to tell what was clean or dirty. It was also difficult to inspect the carpets well due to the clutter. The areas described above were observed in the presence of the facility Administrator at the time of the tour.	I 566		

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
	170501	A. BUILDING: _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NDRTH IDWA TRANSITIDN CENTER	408 FIRST STREET NW MASON CITY, IA 50401

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I 599	Continued From page 17	I 599		
I 599	62.21(8)a Physical facilities and maintenance 481--62.21(135C) Physical facilities and maintenance. 62.21(8) Maintenance. Each facility shall establish a maintenance program to ensure continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout the facility. In facilities over 15 beds, this program shall be in writing and be available for review by the department. a. The buildings, furnishings, and grounds shall be maintained in a clean, orderly condition and be in good repair. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building and furnishings were kept in good repair. Findings include: Observations made during an environmental tour on 12/2/13 from 2:15 pm to 3:10 pm revealed the following: a.) Bedroom #8 had several large areas of the carpet that were stained and discolored. b.) The laundry room had a combination sink/cabinet. The cabinet had a door that was falling off and needed repaired/replaced. c.) A bathroom upstairs on the women's side had a loud vent fan that was in need of addressing. d.) A bathroom upstairs on the men's side had a	I 599		

DEPARTMENT DF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	170501	A. BUILDING: _____ B. WING _____	12/04/2013

NAME DF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH IOWA TRANSITION CENTER	408 FIRST STREET NW MASON CITY, IA 50401

(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 OEFICIENCY)	(X5) COMPLETE DATE
I 599	Continued From page 18 drippy faucet and a vent fan that was loud and needed addressing. e.) A bathroom on the main floor used by bedrooms #1 and #2 had a large basketball size area of damaged drywall near the ceiling that was in need of patch/repair. The areas described above were observed in the presence of the facility Administrator at the time of the tour.	I 599		
I9999	Final Observation Although not a deficiency, the following concern was noted: On 12/2/13 at approximately 2:40 pm the facility Administrator was observed unlocking a cabinet that contained several resident medications. These were either extra medications, or or ones that did not fit into the locked resident medication boxes. Interview with the Administrator at the time of the observation revealed he was not qualified to pass medications. In addition, the only staff at the facility who was qualified was the LPN. The facility was informed that only staff who are qualified to pass medications in an RCF/PMI facility (physicians, nurses or Certified Medication Aides) are allowed to have access to keys to medication cabinets/boxes.	I9999		

North Iowa Transition Center

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E-Mail Address: nitc@nitc-ia.org

1/13/14

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111 Second St. N.E.
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Fax: (641) 424-3747

NORTH IOWA TRANSITION CENTER RESPONSE:
IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
HEALTH FACILITIES DIVISION
PLAN OF CORRECTION

Number: FC#5112
Facility Name: NORTH IOWA TRANSITION CENTER
Facility Address: 408 First St. NW
City: Mason City, Iowa 50401

HEALTH FACILITIES
JAN 09 2014

Report Date: 12/20/13
Survey: December 2 – 4, 2013

ID Prefix Tag C-215, I-224, and Rule or Code Section 62.9(5) and 50.9(9)a

Nature of Violation: Based on interview and record review, the facility hired Staff B before obtaining an evaluation from the Department of Human Services (DHS) regarding additional criminal charges incurred since the last DHS evaluation was completed.

PROVIDER'S PLAN OF CORRECTION:

Procedures are currently in place that clearly indentifies that new hires may not begin work until all background checks are complete and clearances/evaluations are received. In this case, procedures were not followed. An additional management level has been added to the hiring process. Effective immediately, pre-employment packages will be reviewed by the executive director prior to the first day of employment.

Completion date: Immediately

ID Prefix Tag I-179, I-180, I-181, I-182 and I-186

Nature of Violation: Documentation for training does not exist for: (1) First aid, (2) Human needs and behavior, (3) Problems and needs of person with mental illness, (4) Medication and (8) Fire safety, disaster, and tornado preparation.

PROVIDER'S PLAN OF CORRECTION:

A training manager will be appointed in writing. The training manager will ensure compliance with Chapter 62 requirements. The training manager will develop a training plan and provide a monthly report to the executive director which will include training provide, attendance and

attendance gaps which need to be addressed. The training plan is currently under development and will be in place no later than mid-February.

Completion date: February 15, 2014

ID Prefix Tag I-231

Nature of Violation: Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed had obtained a physical prior to admission

PROVIDER'S PLAN OF CORRECTION:

The Center's screening form, Physician's Authorization for Program Participation, was modified to include the physical exam requirement. The screening form will be used by staff as a checklist to ensure all preadmission requirements are met prior to the member's arrival. The administrator will review the screening form and sign off on the form before authorizing an admission.

Completion date: Immediately

ID Prefix Tag I-341 & I-374

Nature of Violation: (I-341) Qualified staff shall ensure that residents are able to take their own medication. (I-374) Each resident shall be given verbal and written information about all medications the resident is currently using, including over-the-counter medications.

PROVIDER'S PLAN OF CORRECTION:

On December 19, 2014, NITC received a contract from Magellan Behavioral Services which increases the reimbursement rate for residential services. This increase was based on a justification to add nursing/medication aides to the staff. The anticipated effective date of the increase is for some time in February 2014. When the increase is put into place, NITC will be able to recruit and hire additional staff qualified to assist residents with medication.

In the meantime, the one nurse the Center has on staff will begin daily reviews of Medication Administration Record for errors related to dates and time of medication. In addition, both verbal and written information will be provided to residents on an on-going basis. The information provided will be documented in the members' charts on a locally created form. The administrator will conduct unannounced reviews of the MAR as well as cross-check charts to ensure proper documentation.

Completion date: Immediately for MAR reviews and providing information. 30-60 days (depending on Magellan contract effective date and recruiting success) for hiring additional medication qualified staff.

ID Prefix Tag I-361

Nature of Violation: Based on observation, interview and record review, the facility failed to obtain a physician order certifying Resident #2 was capable of injecting her/his own insulin.

PROVIDER'S PLAN OF CORRECTION:

The Center's screening form, Physician's Authorization for Program Participation, was modified to include the requirement for a provider order for residents to self-administered injectable medication. The authorization form will be used by staff as a checklist to ensure all preadmission requirements are met prior to the member's arrival. The administrator will review the screening form and sign off on the form before authorizing an admission.

Completion date: Immediately

ID Prefix Tag I-390

Nature of Violation: Inspection of the condition of stored drugs shall be made by the administrator and a licensed pharmacist not less than once every three months.

PROVIDER'S PLAN OF CORRECTION: An Inspections Records file already exists and the pharmacy schedule has been added to ensure quarterly inspections are carried out. The Administrator will ensure the pharmacy schedule is adhered to. In addition, the executive director will add all periodic inspections to his calendar to ensure inspections are being carried out on time, every time.

Completion date: Immediately

ID Prefix Tag I-566

Nature of Violation: Based on observation and interview, the facility failed to maintain all areas of the facility in a clean, orderly condition. Specifically: bedrooms that had clothing and personal items that were disorganized.

PROVIDER'S PLAN OF CORRECTION: NITC will begin weekly inspections and provide encouragement and instruction to clients concerning the "orderly condition" of their rooms. Condition of the rooms as well as the encouragement provided will be documented in the members' charts. In addition, room conditions will be noted during daily rounds (four times per day) and follow-up, when necessary, will be provided. The administrator will periodically observe room conditions and follow-up when necessary.

Completion date: Immediately

North Iowa Transition Center
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ID Prefix Tag I-599

Nature of Violation: Based on observation and interview, the facility failed to ensure the building and furnishings were kept in good repair. Specifically: a) large areas of the carpet that were stained and discolored, b) cabinet had a door that was falling off and needed repaired/replaced, c) A bathroom with a loud vent fan, d) drippy faucet and a vent fan that was loud, e) damaged drywall near the ceiling.

PROVIDER'S PLAN OF CORRECTION: An enhancement to the maintenance program will be set into place to ensure specific areas are inspected. This will be documented in a checklist which will be added to the monthly inspection binder. The checklist will be conducted by a staff member and reviewed by the administrator. Deficiencies will be prioritized by the administrator and identified to the maintenance staff for correction. The status of the deficiencies are:

a) Carpet will be cleaned or replaced by January 10th as the current occupant will be moving out on January 2nd.
b) Cabinet door fixed – Dec 27, 2013
c) Bathroom vent fan will be inspected, cleaned or replaced if necessary by January 17, 2014.
d) Dripping faucet fixed – Dec 27, 2013. Vent fan will be inspected, cleaned or replaced if necessary by January 17, 2014.
e) Drywall is fixed – Dec 27, 2013. Painting will be completed by January 10, 2014.

Completion date: February 28, 2013

Respectfully submitted by: Brian T. Shotwell 12/30/13

Brian T. Shotwell, Executive Director **Date**