Department of Inspections and Appeals
Health Facilities Division
Citation

Number **6320**	Fine amount reduced by 35% to $325.00 on November 8, 2016 pursuant to Iowa Code Section 135C.43A		**Report date** **October 21, 2016**
Facility name **New Hope Village**		**Survey dates** **October 10-12, 2016**	
Facility address **1211 East 18th Street**		**62882-I**	
City **Carroll, IA 51401**	**HL**		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
64.60	**481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.** **Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility.** **This rule is intended to implement Iowa Code Section 135C.2(3).**	**II**	**$500.00**	**Upon Receipt**
W153	**483.420(d)(2) STAFF TREATMENT OF CLIENTS** **The facility must ensure that all allegations of mistreatment, neglect or abuse as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.**			
64.33(1)	**481—64.33(135C) Allegations of dependent adult abuse.** **64.33(1)** *Allegations of dependent adult abuse.* Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481—Chapter 52. (I, II, III)			
52.2(2)a	**481—52.2(235E) Persons who must report dependent adult abuse and the reporting procedure for those persons.** **52.2(2)** Reporting suspected dependent adult abuse in facilities or programs. *a.* If a staff member or employee is required to make a report pursuant to this rule, the staff member or employee shall immediately notify the person in charge or the			

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	person's designated agent who shall then notify the department within 24 hours of such notification or the next business day.			
235E.2(3)(a)	**Iowa Code section 235E.2(3)(a)** **3. *a.* If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within twenty-four hours of such notification. If the person in charge is the alleged dependent adult abuser, the staff member shall directly report the abuse to the department within twenty-four hours.** **DESCRIPTION:** Based on interviews and records review, the facility failed to ensure staff immediately reported allegations of abuse/mistreatment to the administrator. Consequently, the facility failed to report all allegations of abuse/mistreatment timely to the Department of Inspections and Appeals per state law and facility policy. This affected 1 of 1 client (Client #1) identified during the investigation of incident #62882-I (Client #1). Findings follow: Record review on 10/10/16 revealed a facility Suspected Abuse Form signed by the Nurse Coordinator on 8/26/16. The document recorded the Nurse Coordinator's observations of the Client Support Staff/Shift Leader's (CSS/SL) interactions with Client #1 on 8/23/16. The report noted Client #1 screamed and yelled and the CSS/SL yelled back at him/her. In addition, the CSS/SL reportedly threatened to take Client #1's personal belongings. The document noted the date of the incident as 8/23/16 and the date reported as 8/25/16. Further review revealed a copy of an e-mail the Nurse Coordinator sent to the Residential Supervisor (RS)			

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	describing the incident on 8/23/16. The e-mail was sent on 8/25/16 at 10:03 a.m. Additional record review revealed Witness Statement Forms signed by Client Support Staff (CSS) A and CSS B on 8/29/16. CSS A wrote her account of an interaction between the CSS/SL and Client #1 on 8/23/16. She noted the CSS/SL invaded Client #1's personal space and told him/her to listen or she would take his/her cell phone. CSS B documented the CSS/SL told Client #1 if he/she didn't stop yelling, the CSS/SL would take his/her cell phone. Record review of the facility Prevention and Reporting of Dependent Adult and Child Abuse policy on 10/10/16 revealed the policy stated, "Any employee who witnesses an incident that might be considered abuse shall verbally report the incident to the supervisor of the area in which the incident occurred. Immediately means without delay following recognition of the incident." When interviewed on 10/11/16 at 8:55 a.m., the Nurse Coordinator said she heard Client #1 yelling and crying from her office around 2:00 p.m. on 8/23/16. She recalled she went to the dining room and the CSS/SL yelled at Client #1 and threatened to take a personal possession. She stated CSS A and CSS B sat in the dining room with Client #1 and witnessed the interaction. The Nurse Coordinator instructed CSS B to talk with the supervisor and CSS A to write down what she saw/heard. She confirmed she thought about the interaction later and determined it might be abuse so she sent an e-mail to the RS on 8/25/16. She stated she also sent the e-mail to the Campus Residential Director. The Nurse Coordinator failed to report the incident to anyone until 8/25/16. When interviewed on 10/11/16 at 11:50 a.m., CSS A confirmed she heard the CSS/SL tell Client #1 she would take away his/her cell phone on 8/23/16. She stated she			

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	feared the CSS/SL might yell at her so she failed to report the incident to anyone at the time. When re-interviewed on 10/12/16 at 10:40 a.m., she confirmed the Nurse Coordinator instructed her to write down what she saw/heard on 8/23/16. She stated she failed to write anything down until the facility conducted an internal investigation. When interviewed on 10/11/16 at 1:00 p.m., CSS B confirmed she witnessed an incident between the CSS/SL and Client #1 on 8/23/16. She recalled the CSS/SL leaned down into Client #1's face and told him/her she would keep his/her cell phone all night if the behavior continued. She confirmed she failed to tell anyone until the next day (8/24/16) when she talked to the RS. When interviewed on 10/10/16 at 3:30 p.m., the RA confirmed she spoke with CSS B on 8/24/16 at approximately 3:30 p.m. She said CSS B told her the CSS/SL had been disrespectful to Client #1 on 8/23/16 and threatened to take away his/her cell phone. She questioned whether the phone was taken and learned it wasn't. She assured CSS B she would follow up with the CSS/SL. She said she intended to follow up with the CSS/SL on 8/27/16 when she returned to work. The RA confirmed she received an e-mail from the Nurse Coordinator on 8/25/16, but failed to read the entire e-mail because she had talked with CSS B and assumed she already knew all the information. She recalled the Campus Residential Director called her on 8/26/16 and questioned her about the incident. The RA said she read the entire e-mail from the Nursing Coordinator and realized she failed to report an allegation of abuse. When interviewed on 10/12/16 at 9:34 a.m., the Campus Residential Director stated she read an e-mail from the Nurse Coordinator in the afternoon on 8/25/16. She confirmed she spoke with the RA about the incident on 8/26/16 and initiated an internal investigation due to an			

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	allegation of abuse. When interviewed on 10/12/16 at 9:15 a.m., the Incident Management Specialist confirmed she conducted an internal investigation of alleged abuse between the CSS/SL and Client #1. She confirmed the incident occurred on 8/23/16 but staff failed to immediately report the incident per facility policy. She further confirmed she reported the incident to the Department of Inspections and Appeals on 8/26/16. **FACILITY RESPONSE:**			

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