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
	890403	A. BUILDING: _____ B. WING _____	C 11/22/2016

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 The following deficiencies were cited during the investigation of Incident 63090 and Incident 63961:	R 000		
R 834	57.22(3)c Orientation and Service Plan 481-57.22(135C) Orientation and service plan. 57.22(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	R 834	See attached Plan of Correcti DD	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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R 834	Continued From page 1 failed to update service plans as needs changed for 1 of 3 residents reviewed (Resident #1). Findings are as follows: Resident #1 was admitted to the facility on 7/15/16. The service plan dated 7/27/16 noted Resident #1 could "become physically aggressive towards others." None of the three goals listed in the service plan addressed aggression towards others. Resident #1 had acts of aggression on the following dates: 7/30/16, 7/31/16 (twice), 8/14/16, 9/5/16, 9/9/16, 9/12/16, 9/15/16, 9/16/16 (twice), 9/18/16, 9/19/16 (twice), 9/21/16 and 9/22/16. The resident was discharged from the facility on 9/22/16. No modification was made to the service plan prior to Resident #1's discharge. An email from the Administrator to the resident's mother on 9/7/16 stated she was "going to create a behavior plan." The Administrator sent an email to another agency staff on 9/15/16 asking to have some examples of behavior plans sent to her. The Administrator stated in an interview on 11/21/16 at 11:50 AM that a behavior plan needed to be written but she hadn't had time to complete one due to Resident #1's escalating behaviors.	R 834		
R1024	57.34(3)c Safety 481-57.34(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. (I, II, III) 57.34(3) Resident safety.	R1024		

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R1024	Continued From page 2 c. Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure the safety of 2 of 3 residents reviewed (Resident #2 and Resident #3). Findings are as follows: 1. Resident #2 was diagnosed with Severe Intellectual Disability and Hypothyroidism. An incident report dated 7/31/16 indicated Resident #1 attempted to hit Resident #2 but was redirected. On 9/9/16, an Incident Report was written which stated Resident #1 kicked Resident #2 three times in the private parts and thigh and hit him/her in the arms 2 times while yelling and screaming. This resulted in bruising. On 9/18/16, Resident #1 pinched Resident #2 on the right arm and slapped him/her with an open hand in the same area. This incident did result in bruising according to an interview with Staff C on 11/22/16 at 8:47 AM. On 9/19/16, an Incident Report was written noting Resident #1 bent back the fingers on Resident #2's hand and attempted to pinch. No injury was noted. On 9/22/16, Resident #1 was found in Resident #2's room hitting Resident #2 on the right hand and arm. Bruising was seen on Resident #2's arm from the elbow to wrist, according to Staff C in interview on 11/22/16 at 8:47 AM. An interview with Staff B on 11/22/16 at 8:45 AM confirmed the staff was concerned about the effects of the aggression from Resident #1 toward Resident #2. Staff C stated Resident #1	R1024		

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R1024	Continued From page 3 targeted Resident #2 when interviewed on 11/22/16 at 8:47 AM. Both staff stated the plan to keep Resident #2 safe was to keep him/her separated from Resident #1. Staff C noted that when staff were busy Resident #1 would sometimes go into Resident #2's bedroom. An interview on 11/21/16 at 2:13 PM with the director of the vocational program both residents attended revealed Resident #1 had "significant behaviors and was rude" to Resident #2. The Administrator stated during an interview on 11/21/16 at 9:45 AM that Resident #1 appeared to target Resident #2. On 11/21/16 at 3:27 PM, the Administrator stated Resident #2 usually sat in the lounge area by the nurse's station where staff could closely monitor him/her. Staff were instructed to keep Resident #1 and Resident #2 apart. 2. Resident #3 was diagnosed with a personality disorder, dissociative disorder, major depression and diabetes. The resident left the facility on 10/24/16 on a public transit bus to attend a medical appointment. Resident #3 informed Staff B she had "made arrangements" to attend the appointment. The resident returned to the facility later that day with no problems/injuries noted. Following the incident, Staff B learned Resident #3 was not allowed to be away from the facility without supervision. In an interview with Staff B on 11/21/16 at 2:05 PM, she stated at the time she thought Resident #3 had permission to go on the bus alone. In an interview on 11/22/16 at 11:05 AM, the Administrator said the general rule was that all residents were to receive 24-hour supervision unless a statement was received from a psychiatrist stating the resident can have alone	R1024		

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R1024	Continued From page 4 time. Resident #3 did not have such a statement.	R1024		

PLAN OF CORRECTION

Provider/Supplier Name:	Center Village of Tenco
Street Address, City, Zip:	19248 Maple Avenue
Date of Survey:	November 22, 2016

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	890403

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
R 000	The following deficiencies were cited during the investigation of incident 63090 and incident 63961. Tenco's Action Plan for each deficiency has been included.	NA
R 834	57.22(3)c Orientation and Service Plan 481--57.22 (135C) Orientation and Service Plan 57. 22(3) Service Plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed need, such as activities of daily living, rehabilitation, activity and social behavioral, emotional physical, and mental health. (I,II,III) c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all the individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I,II,III) ***Center Village of Tenco will follow guidelines regarding section 57.22(3) by modifying goals and objectives as the resident's needs change.*** ***Corrective Action Plan:*** ***Service plans will be initially developed based on assessed need and updated, as often as necessary, as residents needs change. Communication related to service plan changes or changes in the resident's condition shall occur within five working days and will be communicated to all staff responsible for executing the plan, through in-house staff meetings, communication logs, etc. During this time, staff will be offered an opportunity to ask questions to fully understand the implementation of changes. Changes to service plans could include goal revision, staffing/supervision requirements, and behavior modification techniques to name a few.***	Effective Immediately

Per correspondence with facility, the Administrator will ensure compliance to the POC. DD

V [initials] 12/29/16

DD 12/29/16

R 1024	57.34(3)c Safety 481-57.34(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. 57.34(3) Resident Safety c. Residents shall receive adequate super vision to ensure against hazard from themselves, others, or elements in the environment. (I, II, III) ***Corrective Action Plan:*** ***Center Village of Tenco will ensure the safety of its' residents and staff as outlined in section 57.34(3)by ensuring adequate supervision against hazard from themselves, others, or elements in the environment. This will include but not be limited to reviewing supervision requirements and/or needs of residents and modifying safety plans as needed.*** ***Tenco, as an organization, will review and revise all RCF policies and procedures specifically related safety and supervision.***	Effective Immediately Within 30 Days