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
	750562	A. BUILDING: _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIDE GROUP AT LINCOLN STREET	1240 LINCOLN STREET NE LE MARS, IA 51031

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R 000	Initial Comments The following deficiencies were identified during the investigation of Incident #68024-I and Complaint #68693-C.	R 000		
R 830	57.22(3)a 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) a. The service plan shall include measurable goals and objectives and the specific service(s) to be provided to achieve the goals. Each goal shall include the date of initiation and anticipated duration of service(s). Any restriction of rights shall be included in the service plan. (I, II, III) This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure services to achieve goals were specific for 1 of 4 residents reviewed (Resident #1). Findings include: Review of Resident #1's current service plan revealed goals with start dates of 1/12/17. The resident had a Behavioral Program goal to decrease negative behaviors including suicide	R 830	See attached Plan of Correction DD — 7/28/17 AC 8/1/17	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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R 830	Continued From page 1 attempts, self-harm, PICA, assault or aggressive behaviors and property destruction. The Interventions related to this goal revealed the facility would have an extra staff available each shift to be 1:1 with the resident as needed to aide in decreasing negative behaviors. The intervention section documented when the resident was doing well staff would complete direct care staff tasks, but when needed to sit or monitor the resident, they would remain with him/her. There were no guidelines included to determine when 1:1 supervision needed to be utilized. On 6/20/17 at 3:00 p.m. Staff A confirmed the service plan noted 1:1 should be used as needed for the resident. However, Resident #1's level of supervision was to be 1:1 from 6:00 a.m. - 8:00 p.m. On 6/21/17 at 9:29 a.m. interview with Staff F confirmed the service plan noted 1:1 supervision would be utilized as needed. Staff F stated the Team Leader and the Administrator decided when 1:1 supervision needed to go into effect. Staff F said the facility used to schedule three direct care staff per shift but due to funding changes, only two direct care were now being scheduled. If Resident #1 was to have 1:1 supervision, one of the two scheduled staff had to provide it. Staff F confirmed the facility questioned Resident #1's level of care and added they have attempted to find placement for Resident #1 but have been unsuccessful so far. On 6/22/17 at 11:42 a.m. Staff A and Staff B confirmed the level of Resident #'1's supervision needed to be clarified and staff needed to be trained accordingly as to what 1:1 supervision meant.	R 830		

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R 830	Continued From page 2 On 6/27/17 at 3:56 p.m. Staff F was asked why some staff reported Resident #1's supervision to be 1:1 from 6:00 a.m. - 8:00 p.m. but the service plan as written by Staff F failed to include this level of supervision. Staff F reported the nurses had never informed her of this change in supervision. Staff F said nurses can make changes in direct supervision of the resident for safety reasons. However, they were to inform her in order for the service plan to be updated. Staff F thought with all the staffing changes in nursing, Resident #1's level of supervision changes were not always communicated.	R 830		
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	R 834		

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R 834	Continued From page 3 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 record review the facility failed to update service plans as needs changed for 1 of 4 residents reviewed (Resident #1). Findings include: On 6/20/17 at 1:19 p.m. record review revealed Resident #1 was admitted to the facility on 12/10/15 with a history of self-harm. Review of incident reports revealed the resident self-harmed on the following dates: 1/27/17, 2/16/17, 2/17/17, 3/19/17, 4/30/17 (twice), 5/16/17 (twice), 5/25/17 and 6/13/17. At least six of these incidents resulted in hospitalizations. Review of Resident #1's current service plan revealed goals with start dates of 1/12/17. The resident had a Behavioral Program goal to decrease negative behaviors including suicide attempts, self-harm, PICA, assault or aggressive behaviors and property destruction. The Interventions related to this goal revealed the facility would have an extra staff available each shift to be 1:1 with the resident as needed to aide in decreasing negative behaviors. There were no guidelines included to determine when 1:1 supervision needed to be utilized. The resident also had an Incentive Program to earn activities by not displaying negative behaviors. Neither of these goals were amended or updated in an effort to decrease the resident's frequent self-harm	R 834		

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R 834	Continued From page 4 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. 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 observation, interviews and record review, the facility failed to ensure Resident #1 received adequate supervision to ensure against hazards from self. The sample consisted of 4 residents. Findings include: On 6/20/17 at 1:19 p.m. record review of the current Care Plan, identified an admission date into the facility on 12/10/15. The Plan identified the resident had diagnoses including diabetes mellitus, type 2 (non- insulin dependent), obesity, schizoaffective disorder and hypertension (elevated blood pressure). On 6/20/17 at 1:50 p.m. Staff A reported Resident #1's level of supervision consisted of 1:1 [one on one] from 6:00 a.m. - 8:00 p.m. Review of Resident #1's incident reports on 6/19/17 at 3:00 p.m. identified the following	R1024		

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R1024	Continued From page 5 incidents of self-harm: - On 1/27/17 at 3:00 p.m. Resident #1 used a cigarette lighter to scrape self. The behavior escalated and Resident #1 swallowed 2 AA batteries that required hospitalization. Resident #1 returned to the facility on 1/31/17. - On 2/16/17 at 4:15 p.m. the resident slammed head into the wall and made the head bleed. - On 2/17/17 at 4:45 p.m. the resident in his/her room and tied strips of a torn T shirt around his/her neck because he/she wanted to go to the hospital. Resident #1 exited the room and requested staff cut the T-shirt from his/her neck. The resident transferred to the hospital and returned to the facility on 2/20/17. - On 3/19/17 the resident used a pop can to cut his/her left wrist while in the bathroom. - On 4/30/17 at 5:45 p.m. the resident removed the clock from the pool room wall and removed the batteries. Resident #1 swallowed the batteries. At 7:50 p.m. Resident #1 ripped pieces from a T- shirt and tied them around his/her neck requiring staff to cut it off. As noted on the incident report, Resident #1 was to be checked 4 times per hour when their 1:1 attendant was not otherwise with them. Resident #1 was transferred to the hospital. When the 5:45 p.m. incident took place in the pool room, he/she had a 1:1 staff that failed to maintain 1:1 supervision of the resident. Staff reported the resident asked if he/she could go down and smoke. The resident was allowed to go down stairs without the 1:1 supervision. The staff assigned to supervise the resident went to the nurses' station to chart. - On 5/16/17 at 6:13 p.m. Resident #1 reported to staff he/she stuck a pen into his/her private part while staff was at a meeting. The staff	R1024		

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R1024	Continued From page 6	R1024		

helped remove the pen from the private area.
- On 5/16/17 at 9:00 p.m. the resident ripped pieces of corded cloth from his/her T shirt and tied them around his/her neck. The resident's face turned blue. Staff cut the strings off. Resident #1 then hit head on the door and grabbed the door and hit staff with it. The resident transferred to the hospital.
- On 5/25/17 at 5:16 p.m. the resident took batteries from multiple places and ate them. Resident #1 reported a total of five batteries had been consumed. The resident transferred to the hospital and returned to the facility on 5/31/17. The report indicated some medications were changed and medications added. The hospital reports indicated the resident doing better and more stable.
- On 6/13/17 at 6:00 p.m. the resident swallowed some glass and pieces of a CD (compact disk) and stated he/she was going to kill self. The resident transferred to the hospital.
- On 6/20/17 at 3:00 p.m. Staff A confirmed Resident #1's service plan documented 1:1 would be available as needed to decrease negative behaviors. Staff A stated Resident #1's level of supervision should be 1:1.
- On 6/21/17 at 2:37 p.m. Staff A, Staff B and Staff C confirmed Resident #1's level of supervision at the time of the 5/16/17 incidents was not 1:1. The level of supervision was also not 1:1 on 5/25/17 at 5:16 p.m.
- On 6/21/17 at 5:45 p.m. Staff G (Licensed Practical Nurse) was interviewed and stated Resident #1's level of supervision was always to be 1:1. [one on one]. Staff G stated this was put in place at the time of the resident's admission. Staff G reported Resident #1 asked a former Administrator approximately 6 months prior if his/her 1:1 level of supervision could be lessened. The facility asked Resident #1's psychiatric

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R1024	Continued From page 7 provider who agreed to step down the amount of supervision. Review of the PA-C (Physician Assistant) orders dated 1/23/17 identified an order to decrease 1:1 supervision to the morning shift, but still have staff available until bedtime. The PA-C noted it would be reviewed in one month. Record of the one month review could not be located. Review of the quarterly orders dated 4/10/17 indicated no new orders concerning the level of 1:1 supervision. The PA-C also requested the IHH care coordinator continue to work on placement in the Council Bluffs area. On 6/21/17 at 6:26 p.m. Staff H (Direct Care Worker) was interviewed and stated she was told Resident #1's 1:1 supervision consisted of staying on the same level of the building and keeping the resident in eyesight. Staff H confirmed when doing Resident #1's 1:1 level of supervision on 5/25/17 at 5:16 p.m. she did not keep a visual on the resident and allowed him/her in a room alone for approximately 3-5 minutes. It was during this time the resident swallowed the batteries from a clock. Observations completed on 6/22/17 at 7:24 a.m. identified Resident #1 without 1:1 supervision. Interview with Resident #1 revealed his/her 1:1 staff wasn't in yet. Resident #1 confirmed he/she was to have 1:1 supervision at that time. Interview with Staff I (Direct Care Worker) on 6/22/17 at 10:27 a.m. indicated Resident #1 was to have 1:1 supervision from 6:00 a.m. - 10:00 p.m. She confirmed Resident #1 did not have 1:1 supervision on the morning of 6/22/17 at 7:24 a.m. Staff I said the resident's 1:1 staff were often told to help with laundry, complete charting	R1024		

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R1024	Continued From page 8 and supervise Residents #2, #3 and #4 as well. On 6/22/17 at 11:42 a.m. Staff A and Staff B confirmed the level of Resident #'1's supervision needed to be clarified and staff needed to be trained accordingly as to what 1:1 supervision meant. On 6/27/17 at 1:32 p.m. Staff C (nurse) reported when she started employment with the facility in June 2017 staff often charted they were 1:1 with Resident #1 even when they weren't with him/her.	R1024		

The Pride Group
Helping Others, Help Themselves

8/1/17

DIA Plan of Correction-The Pride Group Le Mars Lincoln

A mandatory staff meeting was held on 6/29/2017 to discuss and review the individual level of supervision need for each consumer. Training and education was held during this meeting for all staff to ensure they knew and understand what 1 on 1 supervision entailed. The company Crisis Management and Risk Behavior Minimization Policy was read and reviewed with staff. This policy was re-introduced to this specific location (Le Mars RCF) on 6/29/2017. A fresh, re-designed Risk Assessment Form (internal tool used to aid with tracking and organization) was also reviewed with all staff and implemented on 6/29/2017. The ongoing completion and monitoring of the forms and tasks will be completed by the Facility Administrator and Director of Nursing.

When a safety risk is identified for a consumer, their level of staff supervision will be increased on an as need basis, dependent on the risk identified, and also reviewed with the consumers' psych doctor. The Psych doctor with be in agreeance and sign-off to the changes in supervision. When an increase of supervision is needed, the directive and narrative will be placed in the consumers plan of care and reviewed as frequently as requested or needed. The facility administrator will monitor the supervision plan.

At the employee monthly In-Service held on 7/18/2017, member safety and supervision policies were reviewed and re-trained which included the following; Consumer Health, Medical and Safety Policy, Supervision of Consumer Policy and Crisis Management and Risk Behavior Policy.

Training was held on 7/21/17 with the Resident Service Coordinator, in charge of the written care plans. Chapter 57 was reviewed and re-educated with Resident Services Coordinator with note that service plans are required to be completed within 30 days of admission. It was also reviewed and re-educated with the Resident Service Coordinator that the service plan will include goals that will be based on individual consumer needs with anticipated completion dates of these goals. If there would be a change in the consumer's service plan the changes will updated immediately in the plan of care by the Resident Service Coordinator and applicable staff will be notified of these changes as soon as they are made. This information will also be relayed to those that work with the consumer outside of the facility. This will be monitored by the Facility Administrator.

Krysten Haan

Krysten Haan- Administrator

7/28/17