Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **6616**	**Fine amount reduced by 35% to $1,300.00 on September 6, 2017 pursuant to Iowa Code Section 135C.43A**		**Date:** **August 22, 2017**
Facility Name: **Penn Center**		**Survey Dates:** **July 31, 2017**	
Facility Address/City/State/Zip **2237 245th Street** **Delhi, IA 52223**			
	HL		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
57.34(3)c **AND**	**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)** **DESCRIPTION:** Based on interviews and record reviews, the facility failed to ensure 3 out of 3 residents reviewed were supervised to ensure against hazards from themselves, others or elements in the environment (Residents #1, #2, and #3). Findings include: On 7/31/17 a review of facility incident reports revealed Resident #1, Resident #2 and Resident #3 eloped from the facility on 7/25/17 at approximately 6:00 PM. The incident report indicated all three residents walked away from the property and were picked up by someone driving a truck. Another resident informed the nurse he/she had witnessed the residents leaving. The three residents were dropped off in Delhi, Iowa (approximately 1.5 miles away). The nurse called 911, and dispatcher informed her there were 3 males/females in the city park that were loud and unruly. Resident #2 was found immediately in a bar in Delhi. Resident #2 became combative with deputies	**I**	**$2000.00**	**Upon Receipt**

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Facility Administrator Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

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	and assaulted an officer. Resident #1 and Resident #3 hung out in the Delhi park for a short time, then went to a lake outside of town and swam. The two residents were seen walking on the highway outside of Delhi between 7:00 and 8:00 PM by an off-duty staff person. The residents were picked up and brought back to the facility. Upon return to the facility, Resident #1 started yelling/swearing and threw a chair. Resident #1 and Resident #2 were taken to jail overnight. Resident #3 slept at the facility. Resident #1 was admitted to the facility on 6/14/17. Resident #1 had eloped at a previous placement but had no issues since admission to the facility. According to head check documentation and an interview with the Assistant Administrator on 8/1/17 at 10:00 AM Resident #1 returned from jail on 7/26/17. Resident #1 was placed back on normal hourly checks and did not receive any increased supervision. On 7/29/17, Resident #1 eloped from the facility a second time according to an incident report reviewed on 7/31/17. Resident #1 had not returned to the facility as of 8/1/17 and according to the Assistant Administrator on 8/1/17 at 10:00 AM, his/her whereabouts were unknown. According to head check sheet documentation, Resident #1 was on normal 1 hour checks at the time of the elopement. On 8/1/17 at 11:30 AM, Staff I stated she last saw Resident #1 on 7/29/17 at 9:45 PM sitting outside at the smoke area, upset and yelling on their telephone.			

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	On 8/1/17 at 1:50 PM, Staff H stated she also last saw Resident #1 on 7/29/17 at 9:45 PM sitting outside at the smoke area upset and yelling on their telephone. On 8/1/17 at 3:00 PM, Staff G stated she came in at 10:00 PM and was not told by 2nd shift staff who was leaving that Resident #1 was upset and yelling on the phone at 9:45 PM, 15 minutes prior to the shift change report . Staff G could not locate Resident #1 during the 10:00 PM head check after Resident #5 reported to Staff G he/she thought Resident #1 may have left the premises because Resident #5 could not find him/her. Resident #2 was admitted to the facility on 7/20/17. Resident #2 had no prior history of elopement concerns according to admission information. According to head check documentation and an interview with the Assistant Administrator on 8/1/17 at 10:00 AM Resident #2 returned from jail on 7/26/17. Resident #2 was placed back on normal hourly checks and did not receive any increased supervision. Resident #3 was admitted to the facility on 3/16/17. Resident #3 had no prior history of elopement concerns according to admission information. According to head check documentation and an interview with the Assistant Administrator on 8/1/17 at 10:00 AM, Resident #3 returned on the night of 7/25/17 and was placed back on normal hourly checks and did not receive any increased supervision. On 8/1/17 at 10:00 AM, the Assistant Administrator confirmed it was the facility's normal procedure to			

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57.22(3)c	increase supervision after any resident returns from an elopement. Staff failed to make supervision increases after the incident on 7/25/17. On 8/1/17 at 10:00 AM, the Assistant Administrator confirmed the above findings. **AND** **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)**			

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	Based on interviews and record reviews, the facility failed to ensure 3 out of 3 residents reviewed had service plans amended to include new assessed needs (Residents #1, #2, and #3). Findings include: On 7/31/17 a review of facility incident reports revealed Resident #1, Resident #2 and Resident #3 eloped from the facility on 7/25/17 at approximately 6:00 PM. The incident report indicated all three residents walked away from the property and were picked up by someone driving a truck. Another resident informed the nurse he/she had witnessed the residents leaving. The three residents were dropped off in Delhi, Iowa (approximately 1.5 miles away). The nurse called 911, and dispatcher informed her there were 3 males/females in the city park that were loud and unruly. Resident #2 was found immediately in a bar in Delhi. Resident #2 became combative with deputies and assaulted an officer. Resident #1 and Resident #3 hung out in the Delhi park for a short time, then went to a lake outside of town and swam. The two residents were seen walking on the highway outside of Delhi between 7:00 and 8:00 PM by an off-duty staff person. The residents were picked up and brought back to the facility. Upon return to the facility, Resident #1 started yelling/swearing and threw a chair. Resident #1 and Resident #2 were taken to jail overnight. Resident #3 slept at the facility. Resident #1 was admitted to the facility on 6/14/17. Resident #1 had eloped at a previous placement but had no issues since admission. The service plan for			

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	Resident #1 only identified the elopement at the previous placement. After the elopement on 7/25/17, the service plan was not amended to include elopement as a current concern or recent behavior for Resident #1. Resident #2 was admitted to the facility on 7/20/17. Resident #2 had no prior history of elopement concerns. After the elopement on 7/25/17, Resident #2's service plan was not amended to include elopement as a current concern or recent behavior for Resident #2. Resident #3 was admitted to the facility on 3/16/17. Resident #3 had no prior history of elopement concerns. After the elopement on 7/25/17, Resident #3's service plan was not amended to include elopement as a current concern or recent behavior for Resident #3. On 8/1/17 at 1:40 PM, the Assistant Administrator confirmed the service plans were not updated to include elopement as a current concern or recent behavior. **FACILITY RESPONSE:**			

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