

**Iowa Department of Inspections and Appeals**  
**Health Facilities Division**  
**Citation**

Citation Number: 6721		Date: December 14, 2017		
Facility Name: Park View Homes		Survey Dates: November 27-28, 2017		
Facility Address/City/State/Zip 2815 Lincoln Way Sioux City, IA. 51106		HL		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
W189	<p>64.60(135C) 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.</p> <p>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.</p> <p>This rule is intended to implement Iowa Code Section 135C.2(3).</p> <p><b>Staff Training Program</b>  <b>CFR(s): 483.430(e) (1)</b>  The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p><b>DESCRIPTION:</b></p> <p>Based on interview and record review the facility failed to ensure staff consistently implemented the facility protocol for client accountability. This affected 1 of 1 client (Client #1) identified during investigation #72329-I. Finding follows:</p>	II	\$500.00	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 (2015).

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	<p>Record review revealed the following:</p> <p>a. Facility Investigation packet documented on 10/30/17 Client #1 went missing during a walk in the Skywalk.</p> <p>b. Investigation summary written by the Administrator, indicated, "(Resident Living Assistant (RLA) A) was the employee responsible for (Client #1) while on the walk... she admitted she knew she was responsible for (Client #1) and should have asked one of the other staff to watch (him/her) if she was unable to properly supervise (him/her)."</p> <p>Additional record review revealed the following:</p> <p>a. The diagnoses of Client #1, age 35 at the time of the incident, included: intellectual disability, seizure disorder, autism, self-abusive disorder and behavior disorder.</p> <p>b. Client #1's safety procedure, dated 7/6/16, indicated, "(Client #1) has a seizure disorder which leads to (him/her) engaging in seizures quite often which consequently has resulted with (him/her) falling..."</p> <p>c. Facility protocol for accountability and communication between staff directed, "... When attending community outings, staff are solely responsible for the members they bring on the outing.</p>			

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	<p>They must physically see their members at all times. If a situation arises and staff's attention is needed elsewhere, staff must communicate with their co-workers to let them know that they will need assistance monitoring their members until the situation is resolved..."</p> <p>Observations on 11/27/17 from 6:37 p.m. to 7:17 p.m. revealed Client #1 walked the skywalk independently with staff visual supervision.</p> <p>Skywalk map indicated approximately .1 to .2 miles staff walked before they discovered Client #1 missing.</p> <p>When interviewed on 11/27/17 at 2:02 p.m. RLA A reported on 10/30/17 she was responsible for Client #1, Client #2, and Client #3. When they arrived at the Skywalk, everyone went to the bathroom on the first floor. When they left the bathroom, RLA A believed Client #1 got back on the elevator with the group. RLA A walked in front of the group with Client #2 and Client #3. RLA A stated she thought Client #1 walked with another staff behind them. According to RLA A, Client #1 did not wander and always stayed with the group. RLA A drew a map of the Skywalk and indicated where the bathroom was and where she remembered the group walking to when they figured out Client #1 was not with the group. RLA A stated they informed the security guard and retraced their steps. They found Client #1 next to the bathroom, Client #1 repeated "bad (Client #1)." RLA A believed Client #1 was missing for approximately 5 to 10 minutes. RLA A</p>			

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	<p>stated Client #1 went missing because she failed to follow the accountability and communicate to the other staff to watch Client #1. She stated clients should be in visual at all times.</p> <p>When interviewed on 11/28/17 at 10:45 a.m. Administrator acknowledged the facility failed to follow the client accountability and communication protocol.</p> <p><b>FACILITY RESPONSE:</b></p>			

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