STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G023	A. BUILDING _____ B. WING _____	C 11/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW HOMES	2815 LINCOLN WAY SIOUX CITY, IA 51106

(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) COMPLETION DATE
W 000	INITIAL COMMENTS Investigation #72329-I was completed and resulted in a deficiency written at W189.	W 000	See attached POC 12/14/17	
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) 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. This STANDARD is not met as evidenced by: 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: Record review revealed the following: a. Facility Investigation packet documented on 10/30/17 Client #1 went missing during a walk in the Skywalk. 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)." Additional record review revealed the following: a. The diagnoses of Client #1, age 35 at the time of the incident, included: intellectual disability,	W 189		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 189	Continued From page 1 seizure disorder, autism, self-abusive disorder and behavior disorder. 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..." 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. 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..." 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. Skywalk map indicated approximately .1 to .2 miles staff walked before they discovered Client #1 missing. 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.	W 189		

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W 189	Continued From page 2 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 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. When interviewed on 11/28/17 at 10:45 a.m. Administrator acknowledged the facility failed to follow the client accountability and communication protocol.	W 189		

✓ 1/11/18 OK 1/9/18

12/14/17

Staff has been re-trained in accountability procedures with an emphasis on communication between employees. This was completed at staff meetings. New employees will also be trained in the accountability procedure. Accountability procedure will be reviewed at least quarterly at staff meetings.

Responsible: Q.I.D.P. and Residential Supervisor
Frequency: On going
Completion date: 12/14/17